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ABSTRACT

The monograph advances a conceptual framework for the evaluation of mental health services provided to chronically mentally ill persons by psychosocial rehabilitation programs. Evaluation mechanisms consistent with the philosophy and programmatic aims of psychosocial rehabilitation programs are identified. An introductory section provides a brief history of the psychosocial rehabilitation movement, proposes a conceptual framework, and highlights existing evaluation publications which may be of use to program administrators. The next five sections describe components of a comprehensive evaluation strategy, focusing on the following dimensions of psychosocial rehabilitation programs: (1) input (agency mission, client characteristics and needs, staff competencies, financial condition); (2) process (program practices, program connectedness, match to need); (3) output (productivity evaluation, staff productivity); (4) outcome (client satisfaction, family satisfaction, client outcomes); (5) output/outcome (cost effectiveness, cost/benefit analysis). Within each section, relevant literature is reviewed, specific techniques described, methodological concerns aired, and resource constraints noted. The final section discusses the implications of evaluation, including the uses of information to improve services, the role of "inside" versus "outside" evaluation, and the potential future directions that evaluation is likely to take. A bibliography and appendix containing a client evaluation survey conclude the document. (JW)

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PROGRAMS: WHAT NEXT?

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PSYCHOSOCIAL REHABILITATION
PROGRAMS: WHAT NEXT?

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PREFACE

Purpose of the Monograph

During the past several years, it has become apparent that the provision of mental health services, especially to persons with severe disabilities, is a complex enterprise that implicates a range of services and that requires a variety of professional and programmatic approaches. It is also increasingly clear that there is a need for an overarching ideology and set of principles to rationalize the system, to provide a continuing vision for the system, and to supply a basis for holding the system accountable.

Advocates for community support programs are being challenged in many states to justify the efficacy and viability of the psychosocial rehabilitation concept through more targeted research. The increasingly visible problems of homeless individuals and the deteriorating conditions in many state psychiatric facilities are intensifying skepticism about recent reforms and are generating a potential reversion to more medically oriented programs.

The past two decades have witnessed a tremendous growth in both the volume and the level of sophistication of research that addresses mental health systems and programs. Much of the resulting literature has focused on community mental health center outpatient programs and hospital based inpatient and outpatient programs. While some of these approaches are useful, there is a need for tools that focus on those issues that are most relevant for planners and administrators of psychosocial rehabilitation programs, given the particular philosophical orientation of this complex program model.

The discrete services evaluation efforts in the field to date, with a few notable exceptions, have not illuminated either the richness of psychosocial programs or the effectivenes of such services in accomplishing their major aims, including community integration, client choice and autonomy, individualization, client participation, and participation in work. The development of evaluation mechanisms that more truly reflect the aspirations of programs for persons with chronic mental health problems ultimately will result in a clearer picture of such programs, helping administrators to communicate psychosocial rehabilitation principles to staff and clients alike.

The following monograph advances a conceptual framework for the evaluation of mental health services provided by psychosocial rehabilitation programs, and more generally, for all mental health programs that purport to serve persons with chronic mental health problems. The framework takes into account the multifaceted character of such programs and the need to build an evaluation construct that recognizes the legitimate objectives of persons receiving services, their families, staff, legislators and the community.

The monograph therefore, identifies those evaluation mechanisms that are consistent with the philosophy and programmatic aims of psychosocial rehabilitation programs. Some of the principles that govern such programs are:

- To assist people to regain those skills and capacities that are necessary for independent functioning;
- To ensure multiple opportunities for client choice and participation in program planning;
- To facilitate the integration of individuals in normal work, community and social activities;
- To maximize individual diginity and personal development;
- To provide services that are tailored to individual needs and circumstances;
- To involve families and other persons in the client's natural support system in the rehabilitation process;
- To promote care in the least restrictive setting;
- To provide a long term commitment to the continuing and changing needs of persons with chronic mental health problems;
- To maximize the use of a range of generic services; and
- To advocate for the needs of persons with chronic mental illness.

The audience for the following material is individuals who are interested in assessing the efficacy and quality of particular psychosocial rehabilitation programs. This includes program administrators, their evaluation staff, boards of directors, and clients and families. Because providers of psychosocial rehabilitation programs are not likely to have extensive resources to conduct highly sophisticated and intensive evaluations, the mechanisms proposed have been selected because of their relative ease of administration.

The monograph is organized into three sections. The first section, the Introduction, provides a brief history of the psychosocial rehabilitation movement, proposes a conceptual framework, and highlights existing evaluation publications which may be of use to program administrators. The next sections describe the components of a comprehensive evaluation stratgy and describes mechanisms aimed at the input, process, output and outcome dimensions of psychosocial rehabilitation programs. Within each section, relevant literature is reviewed, specific techniques are described, methodological concerns are aired, and resource constraints are noted.

The final section discusses the implications of evaluation including the uses of information to improve services, the role of "inside" versus "outside" evaluation, and the potential future directions that evaluation is likely to take.

Method

In order to prepare the monograph, the authors carried out a wide-ranging search for exemplary approaches. First, a computer search was made of relevant data bases. Second, NIMH staff were asked for their suggestions regarding significant but perhaps unpublished literature. Third, key informants in a variety of states were contacted to secure information. Fourth, announcements were placed in newsletters regarding the project, and fifth national mental health organizations were canvassed.

The search for useful tools was also greatly facilitated by members of the project's advisory committee. In the initial phases of the project, the authors contacted a range of persons in the field of mental health and psychosocial rehabilitation with backgrounds as administrators, academics, providers, and advocates. The advisory committee both assisted in identifying sources of information and provided a critical review of the final draft of the monograph.

I. INTRODUCTION

History of Psychosocial Rehabilitation and Community Support Programs

Psychosocial rehabilitation is a philosophical and programmatic approach to the care and treatment of persons with long-term, severe psychiatric disabilities. Its goals are to improve the quality of life of these individuals and to enable them to function in society as independently as possible. Underlying this approach are the assumptions that services should focus on individual strengths rather than disabilities (i.e., a "wellness model"), that environmental supports are necessary to sustain people in their homes and communities (IASPRS, 1985), and that persons with serious mental health problems will respond to services that stress long-term rehabilitation rather than acute, medically-oriented care (Turner and Tenhoor, 1978).

Within the rubric of psychosocial rehabilitation is a rich range of services: vocational training and job placement; training in skills of daily and community living; case management; social, recreational and educational services; and services that generate and sustain natural supports. The aim is to provide a comprehensive range of services to meet the range of potential client needs. Services are provided for brief or indefinite periods, depending on the intensity of the person's problem (IASPRS, 1985).

Coordination of specialized and generic services is an important aspect of psychosocial rehabilitation. It is facilitated by a de-emphasis on specialization, an informality in relationships between staff and clients, and a "functional" orientation (i.e., intervention directed at the development of skills linked to community integration). Clients are encouraged to take part in service planning, delivery and evaluation (Laniol, 1980). In some ways, the psychosocial rehabilitation model is at odds with the traditional community mental health center approach that stresses the presence of particular services rather than the integration of services to enhance functioning.

The psychosocial rehabilitation movement has been evolving since the late 1940's, when a group of former state mental hospital patients in New York organized to found Fountain House, a social club (Pressing et al., 1983). For the first several decades of their existence, psychosocial rehabilitation services tended to operate in the private sector and to take on the character of the leadership of the particular program (Mosher and Keith, 1980).

Psychosocial rehabilitation services became more widespread in the late 1970's stimulated by funding from the National Institute of Mental Health's Community Support Program (CSP). Contributing to the development of CSP were: a recognition of the multi-dimensional service needs of people with severe disabilities, an acknowledgement of the failure of the conventional mental health system, including the community mental health center program, to respond to multiple needs, an openness to new approaches to treatment, and a recognition of the pivotal role played by the states in the design and delivery of services. Although the community mental health movement of the 1960's and 1970's contributed to a philosophy of treating all clients in the least restrictive environment and emphasized service coordination and the need for a range of services, clients with the most severe and persistent disorders often were excluded from the mental health system or were treated inappropriately. (For a detailed history of events and circumstances leading up to the CSP initiative, see Carling, 1984a and Turner & Tenhoor, 1978).

The CSP initiative called for a new conceptual approach to serving people with severe psychiatric disabilities rather than simply an expansion of services. Through the Community Support Program, NIMH contracted with state agencies to demonstrate and replicate strategies for providing comprehensive systems, or community support systems (CSSs), at the local level. Guidelines for service system components were spelled out carefully. In addition to a psychosocial rehabilitation component, as defined above, there were outreach services, services to meet basic needs (e.g., housing, income support, health services, etc.), mental health services, 24-hour crisis services, and legal protection. The CSP contracted with states to improve local services and to run demonstration projects (Tessler and Goldman, 1982).

At its outset (1977-1978), CSP concentrated on non-elderly adults with chronic mental disabilities and the minority client. Housing and employment needs became integral parts of the community support concept. Administrative efforts to encourage interagency collaboration at all levels of government and to clarify financial responsibility were made as well. Means of involving consumers in planning were identified as a process goal (Carling, 1984b).

As CSP became established, three clusters of underserved clients were identified: young adults, homeless people and minorities. Children's services were added as a separate but parallel program in 1984 with the development of the Children and Adolescent Service Support Program. More recently, it has become apparent that the elderly also are an underserved group (NIMH,1986).

History of NIMH Evaluation Efforts in the Area of Psychosocial Rehabilitation

CSP embodies much of the spirit of the psychosocial rehabilitation movement. While not all psychosocial rehabilitation programs are parts of Community Support Systems, psychosocial rehabilitation is, in fact, one of the community support program service components. The evaluation plan for the Community Support Program has followed a logical sequence of steps beginning with the award of an "evaluability" contract by NIMH to Macro Systems, Inc. in 1979. Conceived as the preliminary stage in an overall evaluation plan, that exploratory evaluation focused on broad system level issues. The project tasks included clarifying program goals at the federal, state, and local levels; documenting the program as it actually existed; and developing preliminary evaluation and management options (Macro Systems, 1980).

As a second stage in the CSP evaluation process, NIMH commissioned Human Services Research Institute to review the state of the art in needs assessment for the chronically mentally ill. Objectives of the project included the identification of available data on client characteristics and needs from CSP state reports and the mental health literature; the examination of the comprehensiveness and compatibility of these data; the comparison of the relevant needs assessment findings from the state CSP reports and the literature; and the assessment of the major problems and limitations associated with the collection, presentation and interpretation of the available data (HSRI, 1979).

The third stage in the CSP evaluation strategy was a 1980 NIMH contract to Macro Systems to develop a performance mesurement system and to conduct a short-term evaluation of CSP. Like the earlier Macro Systems exploratory evaluation, this project focused on system level issues and examined the implementation of federal intent at the state and local levels. The Macro Systems report gave the Community Support Program high marks for the development of a consistent and coherent conceptual framework for the conduct of programs, but stressed the importance of developing a body of information sufficient to support and justify the complex ideas and programmatic guidelines that underpin the CSP enterprise. Macro Systems pointed to the need to "isolate CSP effects by studying experimental and comparison groups," to "assess achievement of CSP intermediate and long range objectives," to "develop and pilot test necessary instrumentation and methodological tools for collecting performance indicator data," and to determine the extent to which the "quality of life of the target population has been improved" (Macro Systems).

In response to these recommendations, CSP evaluation proceeded on two fronts: the system level and the client level. In order to examine system level performance, NIMH awarded a contract to Professional Management Associates to conduct a field test of state and local self assessment instruments for community support programs (Stroul, Levine and Mulkern, 1985). These instruments were field tested in 20 states and 94 local CSS areas.

In order to meet the recommendation for a comprehensive client level data base capable of supporting both management and research needs, staff from three cooperating states -- New York, Colorado, and Michigan -- collaborated with staff from NIMH to design the Uniform Client Data Instrument (UCDI). The instrument captures four areas of client related information: demographics, clinical history, adjustment and functioning, and service utilization.

In 1979, NIMH awarded a contract to Market Facts Public Sector Research Group for the purpose of pre-testing the UCDI. During the pre-test, data were collected on 1,471 chronically mentally ill individuals at fifteen CSP demonstration sites and three replication sites. The Market Facts report concluded that it was feasible to collect client data with the UCDI and that case managers were capable of supplying most of this information.

A more recent phase of NIMH's evaluation strategy was the award of a contract to Human Services Research Institute for a multi-state client follow up study (Mulkern, et al., 1986). This research had four sub-studies: a cross sectional study, a longitudinal study, a quality of life study, and a dropout study. This research presented a unique opportunity to develop, for the first time, a comprehensive body of information describing the characteristics, levels of functioning, and service utilization patterns of chronically mentally ill individuals.

This set of research and evaluation projects has contributed to the continued improvement of services for persons with chronic mental illness. Projects have focused on the system level, the state level, local CSS areas, and the client level. With the exception of the client follow-up study mentioned above and a cost outcome study in progress, there has been little research focused on the program or agency level. Since psychosocial rehabilitation centers play such a crucial role in CSP and embody so closely the philosophical underpinnings of the federal initiative, it makes sense to concentrate on these programs. This report is an attempt to fill a gap in CSP-sponsored research by providing recommendations concerning those evaluation research methods that are most appropriate and responsive to the mission and substance of psychosocial rehabilitation agencies.

By helping to shape and clarify the nature of the psychosocial paradigm and the characteristics of the target population, mental health evaluation research to date has laid the groundwork for more systematic analyses of community support services generally and psychosocial rehabilitation services specifically. The next set of tasks involves documentation of program results and program coherence. Such program level evaluation is necessary in order to maintain the dynamic quality of the community support program, to ensure a continuing exploration of new and innovative service techniques, and to build expanded public support for such services.

Conceptual Framework

As noted earlier, the task faced by the authors of this monograph was to provide those interested in evaluating psychosocial rehabilitation with a coherent, inexpensive and responsive set of strategies. In order to place these strategies within some context, it is important to advance a definition of program evaluation. According to Spaniol (1985), program evaluation is: "a systematic, continuous process of providing information about the value of a program for purposes of decision-making" (p. 153). Through this definition, Spaniol stresses that evaluation should be an integral part of the ongoing operation of the agency; constitute a deliberate and permanent feature of the organization; produce data that are valuable to decision makers; and make judgements about the "goodness" or "badness" of agency practices.

In other words, program evaluation differs from evaluation research in that the former is conducted as an adjunct to program administration and is justified by its utility to planning and continual program refinement. The latter is usually a discrete enterprise that is periodic and limited to a narrow range of methodologies (Spaniol, 1985). Program evaluation is more sturdy and programmatic.

In order to understand the relevance of available methodologies to particular dimensions of psychosocial rehabilitation programs, it is important to begin with a conceptual framework. The simplest way to represent the aspects of programs that form the targets or subjects of evaluation is reflected in the flow chart on the following page.

Taking the above general overview as a guide, the next step is to determine those aspects of psychosocial rehabilitation programs that are unique and in line with the particular mission and purpose of such programs.

Inputs. Those inputs with particular relevance to psychosocial rehabilitation include the agency's mission, the level of competetence of staff, the financial condition of the agency, and the needs of the clients.

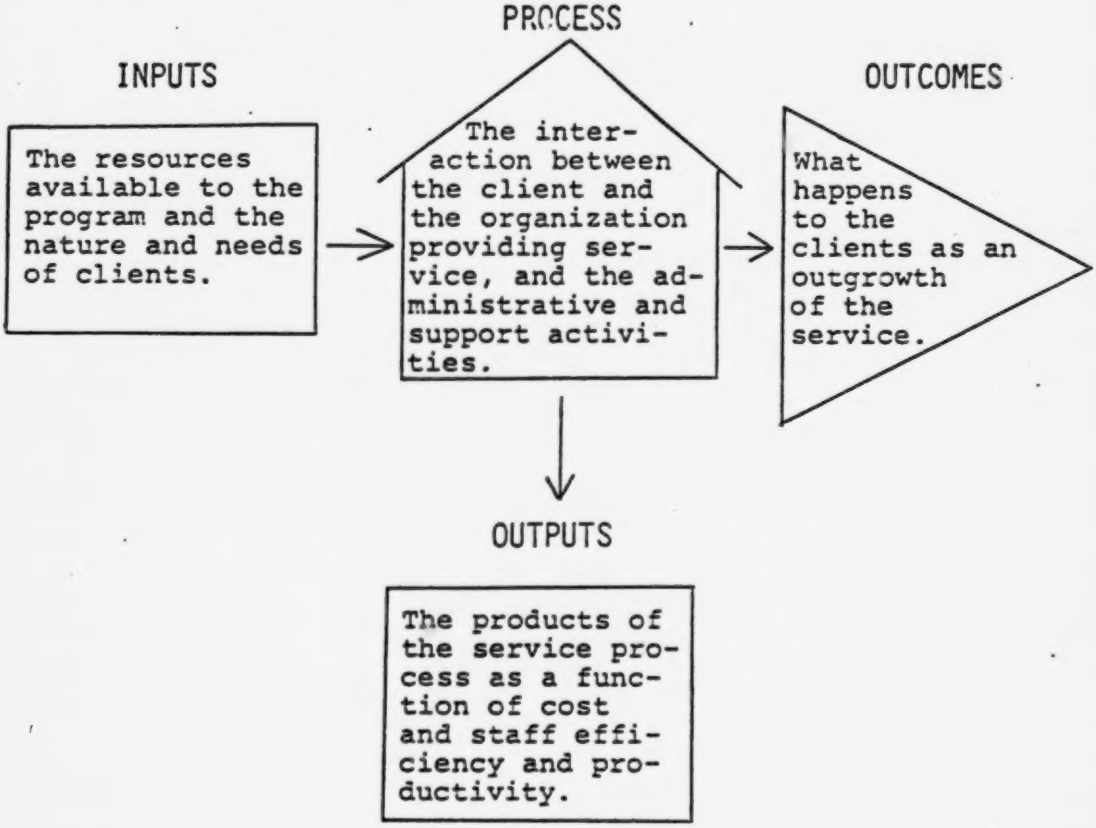
- Mission

A major determinant or input into psychosocial rehabilitation programs is the agency's mission. It is this mission statement that sets the tone for service delivery and that alerts staff, clients, friends and families, and the community to the rehabilitative and reintegration objectives of the program.

- Client Characteristics and Needs

The target groups served by psychosocial rehabilitation

COMPONENTS OF EVALUATION FRAMEWORK



INPUTS: The resources available to the program and the nature and needs of clients.

PROCESS: The interaction between the client and the organization providing service, and the administrative and support activities.

OUTCOMES: What happens to the clients as an outgrowth of the service.

OUTPUTS: The products of the service process as a function of cost and staff efficiency and productivity.

programs tend to be composed of people with complex problems and chronic needs for a variety of mental health and generic services (e.g., housing, employment, income, etc.). It is encumbent on such programs to insure access to those most in need and to be instrumental in providing and/or brokering needed services.

- Staff Competency and Orientation

The success of psychosocial rehabilitation programs depends almost entirely on the extent to which program staff have internalized the mission and values of the agency, have developed a respect for the individuality and dignity of the clients they serve, and have achieved competency in the various service approaches that comprise the program. Therefore, any evaluation of inputs adopted by a psychosocial rehabilitation program must include a means of assessing staff competencies.

- Financial Condition

Psychosocial rehabilitation programs are subject to the vagaries of public funding and as such are vulnerable to destablizing cutbacks and uneven reimbursements. Understanding the agency's financial condition on a regular basis is crucial if program administrators and board members are to make informed resource allocation decisions.

Process. Those aspects of the process of service delivery that are an important focus for psychosocial rehabilitation evaluators include the quality of service delivery and its relationship to accepted psychosocial rehabilitation practices, the extent of community connectedness and the extent to which the program meets client need.

- Program Practices

As the field of psychosocial rehabilitation has evolved over the past 20 years, the sense of what constitutes "best practice" has become increasingly solidified. Through consensus in the field and standards, such as those developed by the Council on Accreditation of Rehabilitation Facilities, there are principles of psychosocial rehabilitation that can be used to judge the quality of service delivery. Such principles include the development of independent living skills, the integration of clients into the community, the maximization of natural supports, and the inclusion of clients in decisions regarding their service plans.

- Program Connectedness

Because persons with chronic mental health problems have multiple and complex needs, psychosocial rehabilitation programs must provide services as well as broker other services -- especially those services that meet basic human needs for food, clothing, and shelter. The extent of interagency coordination is therefore an important element in any evaluation of the service process.

- Match to Need

Again, because of the complexity of service needs among clients of psychosocial rehabilitation programs, it is clearly advisable to review continually the agency's ability to meet the needs of clients as initially anticipated in client plans.

Outputs. The two major program outputs that should be of concern to psychosocial rehabilitation programs are financial productivity, and staff productivity.

- Financial Productivity

The standard measure of human service efficiency is the cost per client served. In psychosocial rehabilitation programs, this ratio is usually understood in conjunction with an assessment of the organizational, programmatic and client variables which contribute to or detract from the agency's productivity.

- Staff Productivity

Conventionally, staff productivity means the number of products completed by staff or the number of objectives achieved. In the psychosocial rehabilitation field, productivity is related to the ability of staff to both complete discrete tasks and to positively affect the lives and circumstances of their clients.

Outcomes. This dimension of any evaluation scheme focuses on program results. Since psychosocial rehabilitation programs have multiple ends, any assessment of outcomes should include client satisfaction, family satisfaction and return to independent functioning.

- Client Satisfaction

One of the significant features of psychosocial rehabilitation programs is the client's relationship to the services. According to psychosocial rehabilitation principles, clients not only use services, but also are encouraged to participate in the making of choices about their care and support. They are both recipients and participants in the planning and evaluation of their services. Thus, any evaluation should take into account the objectives of client participation and autonomy. Clients are also primary sources of information regarding the integrity of the agency's policies vis-a-vis psychosocial rehabilitation principles (e.g., being treated with dignity), and the efficacy of the agency's program (e.g., extent of community integration and return to functioning).

- Family Satisfaction. One of the major actors in a comprehensive program of community support for persons with chronic mental health problems is the family. The stereotype of persons with chronic mental illness is of a loner living in a single room occupancy hotel or in a boarding home; however, statistics indicate that large numbers of people live at home with their families (Ashbaugh, 1983). Until quite recently, programs designed to support such families were virtually non-existant. Counselling did not necessarily contribute to the family's capacity to cope with the problems of their mentally ill family member; rather, it concentrated on the pathology of relationships within the family unit.

In order to ensure that their needs are incorporated into comprehensive psychosocial rehabilitation services, family perspectives on the delivery of services -- their opinions and experiences - should be canvassed as an ongoing part of any evaluation mechanism. In assessing the level of satisfaction of families, it should be kept in mind that their perceptions of service success may vary and in some instances be at odds with those of the clients as well as those of the staff.

- Client Outcomes. The major objective of psychosocial rehabilitation programs, unlike conventional mental health services, is not "cure" *per se*, but the achievement of a level of functioning that is as normal as possible. Such achievement may come through habilitation (i.e., the initial establishment of skills) or rehabilitation (i.e., the resuscitation of skills that have been lost). This includes functioning in a productive work setting and participating in an integrated set of social and leisure time activities. Most of the scales which have been developed to measure outcomes in mental health have focused on the reduction of discrete symptomology. While this is clearly an important activity, it does not tell us whether or not such a reduction in symptomology has resulted in increased functioning in the community, accelerated social integration, expanded personal autonomy, or enhanced quality of life.

The measurement of outcomes in psychosocial rehabilitation programs is complex. The fact that clients are enrolled in multiple service programs offered through a variety of different service systems makes it difficult to attribute observed changes in functioning to the program in question. Even with the development of outcome measures that are reliable, valid and sensitive to change, the problem of causality remains.

Further, the importance of individualized planning in psychosocial rehabilitation programs neccessitates outcome measures that are sensitive to the very personal nature of "success" for each client. Concurrently long-term and episodic, the nature of the typical client's disabilities places further demands on such measures. Change occurs slowly and frequently in a non-linear fashion and outcome measures need to be sensitive to smaller scale gains.

Despite these difficulties, program planners and administrators cannot ignore the fact that client outcome is the bottom line by which program success ultimately is measured. Flawed as it may be, outcome research at the agency level is an integral part of program management.

Outputs/Outcome. The final component of the conceptual framework combines outputs -- cost per unit of service -- with client outcomes. This form of assessment is characterized as cost effectiveness analysis and requires that the other two program dimensions have been addressed.

Existing Evaluation Resources

It is not the intent of this manuscript to describe general methods of evaluation research; this task has already been accomplished to a large extent in several reports sponsored by the National Institute of Mental Health. The first of these is titled Resource Materials for Community Mental Health Program Evaluation (Hargreaves, Atkisson, and Sorenson, 1977). Intended to strengthen the evaluation capabilities of local agencies, this monograph contains articles concerning evaluation research and discussions of selected techniques. It covers a variety of issues:

- Elements of program evaluation;
- Needs assessment and planning;
- Management Information systems;

- Evaluation of the effectiveness of services (this section reproduces selected instruments for use in CMHCs); and
- An extensive bibliography that categorizes the literature under four headings including systems management, client utilization, outcome, and community impact.

The second NIMH document is titled, A Working Manual of Simple Program Evaluation Techniques for Community Mental Health Centers (Hagedorn, Beck, Neubert, and Werlin, 1976). This monograph contains general evaluation material including discussions of the nature of evaluation research and ways in which to link evaluation research to program change. It also describes the administration of program evaluation in a CMHC -- developing an annual plan, choosing topics, designing the evaluation, conducting the research, and maximizing the utilization of the results. Technical sections include methods for research on needs assessment, patterns of use, cost analysis, impacts and outcomes, cost outcome and cost-effectiveness, the effectiveness of consultation and education, quality assessment, and approaches to citizen review.

A third monograph, which might be of use, is Citizen Evaluation in Practice (Bradley, Allard, and Mulkern, 1984). Containing descriptions of citizen involvement in a variety of evaluation studies, this casebook organizes evaluation examples according to five perspectives: the citizen-evaluator's position vis a vis the program being evaluated (e.g., internal or external); the evaluator's level of involvement; the scope of the evaluation; the topics to be studied; and the methods to be used. Each case is described in terms of:

- The type of organization conducting the research;
- Characteristics of the individuals conducting the research (e.g. professional researchers, lay persons, clients, etc.);
- Reasons for the evaluation or monitoring;
- Target of the evaluation or monitoring;
- Problems or issues evaluated or monitored;
- Techniques used;
- Findings of the evaluation or monitoring activity;
- Recommendations;
- Steps taken to ensure implementation;
- Extent of implementation;
- Special barriers to, or supports for, the evaluation; and
- Resources and costs of the evaluation or monitoring.

The usefulness of this monograph lies in its coverage of topics that are frequently omitted in most of the professional literature on evaluation research, specifically the resources required for the research, strategies for disseminating the results, and ways of maximizing the research's impact.

The final NIMH supported publication is titled, Evaluation in Practice: A Sourcebook of Program Evaluation Studies from Mental Health Care Systems in the United States (Landsberg, Neigher, Hammer, Windle and Woy, 1979). The Sourcebook includes a wide range of cases that highlight multiple approaches to program evaluation in both discrete mental health programs and systems of services. The areas covered include needs assessment; patterns of service use; acceptability, availability, accessibility and awareness; client outcome; community impact; indirect services; cost, cost outcome, and cost effectiveness; quality assurance; and mental health program evaluation in the Year 2000. This book is still available from NIMH, and is an enormously useful reference for basic evaluation practices.

II. INPUT EVALUATION

Recognizing that the development of a program evaluation strategy may of necessity occur in stages -- given the need to identify resources and to introduce procedures gradually -- the most logical point to begin is with the input dimension of the program. It is here that the administrator and others concerned about the viability of the program can ensure that the "raw material" which the program has to work with is adequate, that the clients served are appropriate and that client needs have been defined.

Agency Mission

The first task in the evaluation of inputs to psychosocial rehabilitation programs is to assess the agency's mission in an attempt to determine whether it is consistent with the principles outlined in Section I above. There are several ways in which the presence and implementation of a mission can be judged:

1. Review the agency's mission statement to determine whether it addresses the major psychosocial rehabilitation principles.
2. Determine the extent to which the mission statement is made available to staff, board members, agency clients, and family members.
3. Assess how frequently the mission statement is discussed with staff and board members and whether the objectives are reviewed periodically to ensure that the mission remains relevant and up to date.
4. Review personnel policies, in-service training materials and job descriptions to ensure that the agency's mission is inculcated in initial and ongoing staff orientations.
5. Review reports to the board, agency brochures and other formal agency documents to ensure consistency with agency mission in program descriptions.

6. Review service planning protocols to determine the level of client involvement and choice.
7. Review agency procedures to determine how often the views of clients and family members are canvassed to ascertain the level of satisfaction with agency programs.
8. Assess the extent to which skills training and development is directly relevant to increases in independent client functioning and community integration.

There are some tools available that may be helpful to program administrators in assessing their agency's mission. One is the set of exercises in the Community Systems Workbook (DeSisto & Ridgway, 1986). The workbook is organized according to service components that are related directly to psychosocial rehabilitation principles. Each section begins with a description of the service area and a goal/mission statement and continues with a list of discussion questions. The questions attempt to operationalize psychosocial program concepts and specific service approaches. Exhibit 1, which covers the next three pages, presents the section from the workbook on Housing. The entire scope of service components covered are:

1. Integrating Services

    Outreach and Case Finding
    Comprehensive Individualized Assessment
    Comprehensive Individualized Planning
    Facilitating Linkages, Coordination, Advocacy
    Modifying and Creating Resources and Supports
    Transportation
    Monitoring, Evaluating, Reassessing, Revising
    Meeting Special Needs

2. Basic Supports

    Income Supports
    Housing
    Supportive Care and Supervision

EXHIBIT 1

ASSESSMENT OF AGENCY MISSION

Many psychiatrically disabled persons lack access to decent, safe, and affordable housing due to their inadequate income and the generally low availability of subsidized units and low income housing stock, as well as discrimination due to stigma. In addition, the lack of an adequate support network and repeated acute episodes of illness often result in the loss of housing. Without a stable living environment, treatment and rehabilitation have a very low chance of success.

GOAL - TO ENSURE THAT EACH PSYCHIATRICALLY DISABLED PERSON HAS ACCESS TO DECENT AFFORDABLE HOUSING THAT IS MATCHED WITH HIS OR HER SKILLS, RESOURCES, AND GOALS.

HOUSING FUNCTIONS

1. Does the agency/service area actively help each client to work to achieve a decent living environment?
   _____NO
   _____YES

2. Does the agency/service area provide a variety of services to link psychiatrically disabled persons to housing?

   Help in locating housing____________________________________

   Maintaining lists of rental housing____________________________

   Recruiting landlords____

   Linkage to public housing and rental assistance_______________

3. Does the agency/service area provide the resources patients/clients need to secure and maintain housing?

   Subsidized Housing/Housing Supports___________________________

   Subsidized Security Deposits/Loans____________________________

   Assuring Landlord Rent_______________________________________

   Sublet Leased Apartments_____________________________________

   Provide References to Clients_________________________________

   Household Supplies, Equipment and Furnishings_________________

   Moving Patient/Client Belongings______________________________

4. Does the agency/service area work to protect housing/placement short-term hospitalization?____________________________________

____

5. Does the agency/service area have temporary housing available for crisis/respite needs?______________________________________

____

6. Are specialized residential programs for special populations available in the agency/service area when needed?______________

____

____

7. Are there a variety of housing options available? Roommate matching/cooperative apartments?______________________

____

Supported independent living housing options?___________________

____

Non-treatment residential options linked to intensive programs and supports?____

____

Substitute family environments?________________________________

____

Non-institutional small group living?___________________________

____

8. Is there support, education, and consultation available to home care providers (natural families, foster family, spouse, significant other, boarding care providers)?___________________

____

Is there back-up support to landlords?__________________________

9. Has the agency/service area undertaken community or systems advocacy in order to:

increase the availability of subsidized housing?________________

end housing discrimination?____________________________________

reduce stigma and increase community acceptance?________________

____

10. Are there efforts to familiarize patients/clients with their new living environment and community when a move occurs?___________

____

11. Are patients/clients supported in undertaking the activities necessary to find a living situation?

using classifieds/finding unadvertised living situations________

getting utilities hooked up____________________________________

finding and choosing roommates_________________________________

12. Does the agency aid the person with the tasks necessary for them to get settled in a new environment?

moving and decorating____

negotiating rules and responsibilities with roommates___________

budgeting/shopping____

cooking/cleaning____

safety____

13. Does the agency/service area aid the patient/client in maintaining the living situation?____

landlord tenant relations______________________________________

getting along with roommates/others____________________________

14. Does the agency/service area assess and aid the patient/client in the transfer of functional skills when he or she enters a new living situation?____

____

Source: DeSisto, M.J. & Ridgeway, P., Community Systems Workbook, 1986.

3. Treatment Services

   Psychiatric Assessment and Medication
   Psychotherapeutic Services
   Crisis Services
   Drug and Alcohol Services
   Health Care Services

4. Rehabilitation Services

   Skill development (daily living, social skills, vocational rehabilitation)

   Social Rehabilitation (social support network development, social and recreational activities, social stigma reduction).

The questions in the workbook can be administered as a self assessment tool by agency staff, by board members in interviews with staff, or by agency clients also through interviews with staff.

A second guide, Program Analysis of Service Systems (PASS, Wolfensberger and Glenn, 1976), was designed as a monitoring tool in the field of mental retardation. PASS is one of the only scaled survey tools that attempts to operationalize an ideology -- referred to as normalization -- which is premised on integration and the reduction of stigma. While PASS was written primarily for a different field, the principles it espouses are universal; they force an agency to look at the extent to which its programs are individualized, dignity-enhancing, age and culturally relevant, and client-centered. Administrators should review PASS and pick out those items that are the most relevant to their own service approaches and settings.

Regardless of the method used, a continual review of agency mission and its integration into day to day procedures is a crucial first step in ensuring the integrity of psychosocial rehabilitation services.

Client Characteristics and Needs

Clients enter psychosocial rehabilitation programs (or any other service program, for that matter) with an almost infinite variety of characteristics and service needs. The documentation of client profiles and service needs does not constitute program evaluation per se. However, it is a necessary prerequisite to a full understanding of organizational inputs. Systematic reporting of the types of clients entering the program is essential both for service planning and for understanding variations in treatment impact.

Instrumentation and Approach. Most of the information needed to construct client profiles will be available on agency intake forms. It is possible to collect huge amounts of information describing clients coming into programs. In many cases, however, only a few key data elements are used routinely. These include:

- age
- race
- sex
- education
- current living situation
- income sources
- primary diagnosis
- secondary diagnosis
- previous use of mental health services (including inpatient services)

Information on service needs can be collected at the time that the client's treatment plan is developed. In order to assure comparability across cases, this type of information should be recorded on a standard form. In addition, all persons working with clients to develop treatment plans should be trained so that the same service definitions are applied in all cases.

Exhibit 2 is an example of a service record that has been developed by H. Stephen Leff and colleagues at Human Services Research Institute.* Columns one and three are relevant in this context. Columns two and four will be addressed in a later section on "Match to Need".

The left column contains a service taxonomy. The taxonomy should reflect local service patterns and nomenclature. Case managers or service planners indicate whether or not each service is needed by a specific client. If more precision is desired and if the agency feels capable of analyzing further data, case managers can also report the units of service needed (column three on this particular form).

Since service needs change routinely, provision should be made for this information to be updated periodically. If the agency requires that the treatment plan be revised according

---

* This instrument is still under development by Leff, et al. at Human Services Research Institute. Evaluators interested in using the form should contact HSRI in order to obtain a current version.

EXHIBIT 2

SERVICE RECORD

SERVICE COMPONENT	Type Unit	(1) Check If Service In Client Service Plan	(2) # Units Actually Provided To Client Per Month	(3) Services (+ or -) Client Should Ideally Receive With Estimate Of Number Of Units Per Month	Reasons Why Services In Column 3 Not Provided O Fewer/More Unit Than Column 2 (Indicate A That Apply)
RESIDENTIAL					
12a. Specialty Hospital	day	a.1 ______	a.2 ______	a.3 ______	a.4 ______
b. Community Hospital	day	b.1 ______	b.2 ______	b.3 ______	b.4 ______
c. Crisis Beds	day	c.1 ______	c.2 ______	c.3 ______	c.4 ______
d. Respite Beds	day	d.1 ______	d.2 ______	d.3 ______	d.4 ______
e. Basic Residential	day	e.1 ______	e.2 ______	e.3 ______	e.4 ______
f. Specialty Residential	day	f.1 ______	f.2 ______	f.3 ______	f.4 ______
g. Intensive Residential	day	g.1 ______	g.2 ______	g.3 ______	g.4 ______
h. Foster Care	day	h.1 ______	h.2 ______	h.3 ______	h.4 ______
i. Family Subsidy	day	i.1 ______	i.2 ______	i.3 ______	i.4 ______
j. Independent Living	day	j.1 ______	j.2 ______	j.3 ______	j.4 ______
TREATMENT					
k. Emergency Assessment	hours	k.1 ______	k.2 ______	k.3 ______	k.4 ______
l. Mobile Treatment Team	days	1.1 ______	1.2 ______	1.3 ______	1.4 ______
m. Counseling	hours	m.1 ______	m.2 ______	m.3 ______	m.4 ______
n. Family Treatment	hours	n.1 ______	n.2 ______	n.3 ______	n.4 ______
o. Substance Abuse Tx-Outpt	hours	o.1 ______	o.2 ______	o.3 ______	o.4 ______
p. Med Maintenance	hours	p.1 ______	p.2 ______	p.3 ______	p.4 ______
q. Day Treatment (3 hr)	slots	q.1 ______	q.2 ______	q.3 ______	q.4 ______
r. Day Activities (3 hr)	slots	r.1 ______	r.2 ______	r.3 ______	r.4 ______
REHABILITATION					
s. Voc/Ed Assessment (4 hr)	slots	s.1 ______	s.2 ______	s.3 ______	s.4 ______
t. Sheltered Workshop (4 hr)	slots	t.1 ______	t.2 ______	t.3 ______	t.4 ______
u. Supported Work & TEP (4 hr)	slots	u.1 ______	u.2 ______	u.3 ______	u.4 ______
v. Job Finding/Development	hours	v.1 ______	v.2 ______	v.3 ______	v.4 ______
w. Educational Services	hours	w.1 ______	w.2 ______	w.3 ______	w.4 ______
SUPPORT					
x. Case Management	hours	x.1 ______	x.2 ______	x.3 ______	x.4 ______
y. Drop-in Center	hours	y.1 ______	y.2 ______	y.3 ______	y.4 ______
z. General Support	hours	z.1 ______	z.2 ______	z.3 ______	z.4 ______
aa. Protection/Advocacy	hours	aa.1 ______	aa.2 ______	aa.3 ______	aa.4 ______

****

*LIST OF REASONS FOR COLUMN 4

01 Service was not available
02 Service has insufficient capacity
03 Client was refused for behavioral reasons
04 Inability to pay
05 Client refused service
06 Clinician/case manager discretion
07 Accessibility (transportation. handicapped access, etc.)
08 Language or cultural barrier
09 Any other reason not listed above
Specify: ______

to a specific schedule, this would be an ideal time to update the service record. If no such convention exists (and for some reason, cannot be implemented), then the service record should be updated every three to six months.

Staff Competence

Background. A variety of tools to assure the competence of staff working with persons with chronic mental disabilities have been developed over the years at the federal, state and agency level. Certification programs, such as the criteria for psychiatric technicians in California, have formed the basis for ensuring the skill level of particular categories of direct care staff. While these approaches test the acquisition of particular techniques such as medication monitoring, behavior management, and skills teaching, they are not necessarily set within a framework that is relevant to psychosocial rehabilitation programs. Recently, two approaches to ensuring staff comptency within such settings have been developed.

The first, Assessing and Improving the Performance of Psychosocial Rehabilitation Staff (Friday and McPheeters, 1985), was funded through a grant from the NIMH Center for State Human Resource Development. The authors break down competence in psychosocial rehabilitation into five categories: 1) informational, 2) intellectual, 3) interpersonal, 4) intrapersonal, and 5) interventional. Within these categories, this publication identifies a number of specific competencies necessary for workers to perform at optimum level. With these competencies identified, the report describes possible measures

Assumptions and Methodological Issues. It is through the development of competency assessments that the agency communicates its expectations and values. Therefore, this aspect of an agency's evaluation is essential to ensuring the coherence of the agency's program and its capacity to meet its objectives. In line with this notion, Friday and McPheeters assert that an agency first must think through those skills that can be associated reasonably with positive client outcomes. They suggest that each staff person's job description should include intermediate measures of outcomes for the clients whom the workers are rehabilitating. Exhibit 3 lists some sample measures of outcomes from job descriptions.

Additionally, Friday and McPheeters outline a simplified form of "employee credentialing" as a means of ensuring and evaluating competence. The steps involved in developing such a system are described in Exhibit 4.

The key assumption underlying the Friday and McPheeters approach is that the evaluation of competence is not merely a means for setting salaries and determining promotions; rather it is a means of helping workers "achieve more effective and productive performance, and thus greater job satisfaction." In other words, the assessment of staff competence should be a means for communicating the agency's mission and values, identifying those skills most likely to accomplish the mission, and supplying remedial training whenever indicated. The process is greatly enhanced if it is seen by staff as a way of continually improving their abilities rather than as a way of to assess and improve the competence of psychosocial rehabilitation workers. The document also cites the use of agency indicators and performance reviews by clients as means by which staff performance can be assessed. The appendix to the study includes a list of competencies and a questionnaire.

The second assessment method reviewed is part of the Psychiatric Rehabilitation Agency Assessment Program (Center for Rehabilitation Research and Training in Mental Health, undated). The assessment is in some ways akin to an accreditation. Paid for by the psychosocial rehabilitation program, the review includes three parts: system of rehabilitative environments, rehabilitation program components, and staff practice components. The latter is defined as follows:

> The knowledge and attitudes of staff practitioners in each environment about psychiatric rehabilitation and the psychiatrically disabled.
>
> The current level of psychiatric rehabilitation skill demonstrated by the staff. (p. 4)

The methods used by the Research and Training Center to ascertain the nature of staff attitudes and the level of competence include a review of personnel data through group intereviews, written performance measures, staff self assessment of rehabilitation knowledge, and direct observations of staff/client interaction.

Both of these approaches involve a sensitivity to the specific mission of psychosocial rehabilitation programs and a concern for the competencies required of staff to assist persons with chronic mental illness to return to normal community living.

Approach. The manual, Assessing and Improving the Performance of Psychosocial Rehabilitation Staff by Friday and McPheeters (1985), offers the best guide for the assessment of staff competence. Their work distinguishes such assessments in this field from standard competencies measures. Specifically, they note:

> [A] definition of competence for mental health workers includes three concepts that lie beyond the usual concepts of proficiency in knowledge and skills:
>
> --the concept that attitudes and values of the worker are critical to competence;
>
> --the concept that competence requires personal interaction with clients;
>
> --the concept that competence requires effective outcomes for clients, not just proficient performance by workers. (p.26)

This analysis is in keeping with the theme of this monograph -- that discrete aspects of psychosocial rehabilitation programs cannot be evaluated without returning to the values and goals of such programs.

Friday and McPheeters describe several ways of assessing competence: certification and credentialing; supervisor's case conferences; supervisor's performance evaluations; peer conferences and evaluations; client ratings of staff competence and case record audits; and extrapolating from agency indicators (e.g., client drop out rates). They conclude that "the more effective approaches are those that most clearly define the tasks and competence levels required for each worker in contrast to those approaches in which the expectations are more global and nonspecific."

EXHIBIT 3

OUTCOME MEASURES FOR JOB PERFORMANCE

1. Assesses the psychosocial functioning of clients and records these data in the clients' clinical records.

   Supervisors may then evaluate the quality of the worker's psychosocial assessments of clients and whether these were completed in a timely fashion and in the numbers expected.

2. Plans individualized program of incremental goals for and with clients and records these in the clinical record.

   Supervisors may then evaluate the quality of these plans and their timeliness.

3. Models and teaches clients the needed behaviors identified in the plan.

   Supervisors can evaluate both activity records and documentation in the clinical records to assure that these activities are being carried out.

4. Structures opportunities and assigns clients so that they can experience appropriate behaviors according to the treatment plan.

   The worker's success in performing these activities can be evaluated by reviewing the clinical records and client activity reports.

5. Motivates, counsels, and supervises clients to participate in the program as structured.

   This item is more difficult to evaluate. Client contacts regarding these activities should be documented in the clinical records.

6. Challenges inappropriate behaviors of clients and takes actions to correct them.

   This activity should be documented in the clinical record, and also by observing the incidence of inappropriate behaviors.

7. Reassesses psychosocial progress of clients and revises plans or refers clients to community resources, and records these plans and activities.

   This step may be evaluated by observing the plan revisions in the clinical record. It may also be measured by client referrals to community resources, and termination from the program or unit of the program after clients have attained the outcomes defined in the plan.

Source: Friday, J.C. & McPheeters, H.L., Assessing and Improving the Performance of Psychosocial Rehabilitation Staff, 1985.

EXHIBIT 4
STAFF CREDENTIALING

1. Review all job descriptions to assure that they represent the full scope of job duties that are expected of each worker.

2. Develop a list of competencies (i.e. the knowledge, skills, attitudes, and values) required for each position.

3. Develop an orientation program for each employee to every competency and job procedure.

   This should be completed within the first two months of employment through structured training programs or through individualized supervision, reading lists, or other means.

4. Identify a staff person to check each new employee's ability to perform on all of the competency items that have been deemed essential for his/her job.

   When the new employee has successfully met these standards, he or she is "credentialed" by the agency, usually after two to three months, demonstrating initial assurance that the worker has the capacity to perform adequately. At this point, the worker is given permanent status.

5. Evaluate each worker at periodic intervals (e.g.. every six months) on the duties of his/her job description.

   Decisions are made about what deficiencies exist and how they may best be remedied. The worker is than recredentialed if performance is satisfactory. This audit provides the occasion to reevaluate the job description, the overall agency procedures, and the functioning of the program's teams. The worker and the supervisor can jointly explore ways to make the entire unit more effective and productive.

Source: Friday, J.C. & McPheeters, H.L., Assessing and Improving the Performance of Psychosocial Rehabilitation Staff, 1985.

identifying and punishing faults. This former attitude can be reinforced by including staff in the discussions of job descriptions and competency measures.

Issues of staff productivity and the development of criteria to assess the supportiveness of the agency's environment will be treated in the section on output evaluation.

Instruments. The development of instruments to assess competency must be preceded by an analysis of skill components. As noted above, Friday and McPheeters break down required competencies into five parts: informational, intellectual, interventional, intrapersonal, and interpersonal. They use these categories to describe particular skills and knowledge. Exhibit 5 outlines the skills suggested for interpersonal competence. They then recommend that once general competencies have been established, separate skills rankings should be determined for each job description, in order to tailor competency assessment to each job category.

Implementation and Analysis. Arriving at personnel competencies for an agency should involve not just the administrative staff, but all staff affected. In this way, the process is made less threatening and multiple professional viewpoints are reflected. Insofar as monitoring competence, a number of methods are suggested in the Overview above. Competencies should be determined at least through case and supervisory review as well as through client satisfaction surveys. Staff reviews should occur every six months.

EXHIBIT 5

SKILLS REQUIRED FOR INTERPERSONAL COMPETENCE

III. INTERPERSONAL

These are the abilities, such as genuiness, empathy, warmth, and the ability to confront realisitically, that were described by Carkhuff and others. It also includes such interpersonal characterisics as courtesy and positive regard.

III.-1. Ability to tolerate low profile--realization that one may not always be rewarded or recognized for their activities.

III.-2. Ability to feel good about small changes and appreciate positive change in client co-worker --no matter how small

III.-3. Be curious

- a. Be inquisitive, especially in client's concerns
- b. Active desire to investigate and learn

III.-4. Empathy and sensitivity-- have some understanding of the feelings, thoughts and experiences of others, also the ability to sense the feelings and communicate to others (i.e., client, co-workers, agency personnel, etc.), sensitive to the needs of the consumer

III.-5. Have integrity

- a. Honesty--doing what you say you are going to do (i.e., follow through)
- b. Not doing things that will compromise self or clients

III.-6. Genuineness

- a. Authentic, real honest

III.-7. Non-possesive warmth-- ability to establish a caring but not a consuming relationship with the other person

III.8. Have positive regard for clients

- a. Treat clients as individuals without belittling them or making them feel inferior
- b. Like and respect clients
- c. Do not demean or patronize clients
- d. Respect clients dignity and privacy
- e. Avoid "labeling" people with sterotypes or derogatory terminology
- f. Avoid judging persons--consider only their behavior

Source: Friday, J.C. & McPheeters, H.L., Assessing and Improving the Performance of Psychosocial Rehabilitation Staff, 1985.

Financial Condition

Background. An important area of concern for psychosocial rehabilitation programs is the financial stability of such agencies. Given that many of the services provided under the rubric of pyschosocial rehabilitation are not reimbursable under Medicaid and other entitlement programs, agencies are more vulnerable to the ebb and flow of public funding. For this reason, evaluation approaches that assist the agency to assess current financial status are of particular importance. A wealth of references for evaluating an agency's financial condition can be found in business administration and to a lesser extent in public administration literature; however, only one was specific to psychosocial rehabilitation agencies: The Mental Health Statistics Improvement Program (MHSIP) Financial Data Task Force (April, 1986) on financial indices to be included as part of the MHSIP Mental Health Data Standards. These information standards are intended to lead state agencies to collect reasonably uniform data allowing cross-organizational and cross-state comparisons. Such comparisons are essential for informed decision-making. Measurement without comparison is not enough to judge the meaning of the results. (Contact: Wurster, Cecil, R., Division of Biometry and Applied Sciences, National Institute of Mental Health, 5600 Fishers Lane, Rockville, MD 20857.)

There is no shortage of information about cost analysis methodologies per se; however little has been written about the application of these methodologies to psychosocial rehabilitation programs. Nor has much been done to develop simple and inexpensive tools for assessing costs and financial stability in such programs.

Approach. This form of cost evaluation addresses two questions: whether the agency has sufficient resources to meet its expenditure obligations, and more importantly, whether the agency has the needed resources and financial stability to provide the level and quality of service that they are charged to provide. Clearly a most important area of cost evaluation from the agency's viewpoint, the latter also is of import to funding agencies if they are to identify and contend with financially unstable agencies.

Hall (1982) identifies four problem areas that can be addressed in evaluating an agency's financial condition, and lists 21 financial indicators that may be used to evaluate the extent of its financial problems.

Indicators of a Declining Revenue Base

1. Percent revenues per client served
2. Percent of one time revenues
3. Percent of operating deficits
4. Percent of elastic revenues
5. Percent of expenditures for repair and maintenance of fixed assets
6. Percent of unfunded pension liabilities
7. Percent of unrestricted fund balance

Indicators of Dependence on Unstable Revenue Sources

8. Percent of revenues from government
9. Percent of revenues from memberships and contributions
10. Percent of revenues from client fees
11. Percent of restricted funds
12. Percent of available sources of funds used
13. Percent of unreimbursed overhead

Indicators of Increasing Costs for Services

14. Personnel costs per client served
15. Percent of expenditures for support personnel
16. Percent of expenditures for fixed costs
17. Fringe benefits liabilities
18. Percent of nonlabor costs

Indicators of Inadequacies in Fiscal Policy and Management

19. Liquidity
20. Percent of interest earned from investments of current assets
21. Contract efficiency

As Hall explains, it is not necessary to use all 21, nor are all indicators necessarily included. Young (1982) would add some indicators that gauge the adequacy of working capital, arguing persuasively that nonprofit as well as profit service agencies must have working capital in order to acquire fixed assets and to finance growth. Dritna (1980) suggests still others.

III. PROCESS EVALUATION

The second set of evaluation activities that should be added to an overall evaluation strategy are those that assess the integrity, responsiveness, coherence and comprehensiveness of the program. Process evaluation focuses on the day to day operations of the program and is a way of understanding the extent to which service delivery is living up to the norms and ideals of psychosocial rehabilitation practice.

Program Practices

Background. With the exception of the standards developed by the Council on the Accreditation of Rehabilitation Facilities, there are no other national accreditation standards that can be used to assess the content of psychosocial rehabilitation programs. However, there are at least two other tools that can be used to measure services against the governing principles and definitions that are commonly associated with such services. An excellent example of such an approach is the Community Systems Workbook, prepared by DeSisto and Ridgway (1986) for the State of Maine. The document provides a means for systematically assessing the extent to which the program's mission is consistent with psychosocial rehabilitation principles and whether the key system components are in place. The second tool is the Psychiatric Rehabilitation Agency Assessment process developed by the Center for Rehabilitation Research and Training in Mental Health at Boston University.

Much like accreditation in that it is paid for by the agency being assessed, it measures the program against defined psychiatric rehabilitation principles and competencies.

Approach. Two questions should be addressed: is an adequate service mix present, given the agency's mission; and are the services which are in place structured to reflect good psychosocial rehabilitation practices? Finally, the critical elements in the environment periodically must be operationalized and assessed, since the health of any program is dependent on the nature of the environment that is created for staff as well as for clients. (This final set of concerns is dealt with in Output Evaluation in the section on Staff Productivity.)

As noted above the Community Systems Workbook spells out system principles and articulates the components of a comprehensive program that meet the needs of persons with chronic mental illness. The service system functions include integrating services, basic supports, treatment services, and rehabilitation services. Each section is broken down into its component parts and specific discussion questions are posed.

For use with staff and board members, the Workbook is an outstanding tool to determine periodically the vitality of the program. The Workbook can be augmented with questions developed by staff, clients and members of the board. Exhibit 6 displays the discussion questions under, "Linkage, Coordination, Advocacy Functions" (integrating services).

The Psychiatric Rehabilitation Agency Assessment Program, at the Boston University Center for Rehabilitation Research and Training in Mental Health, also provides a mechanism for

EXHIBIT 6

Facilitating Linkages, Coordination, Advocacy

Comprehensive plans require linking psychiatrically disabled persons to multiple services, supports and resources. Without active coordination, many psychiatrically disabled persons will not follow through on referrals, agencies may not follow through on initial plans, and the clients may be denied access to services and supports they require. Advocacy may be necessary to ensure access. Continued coordination ensures that all providers and resources are working together rather than at cross-purposes.

GOAL - TO FACILITATE THE LINKAGES BETWEEN THE BASIC SUPPORT, TREATMENT, AND REHABILITATION SERVICES THAT EACH PSYCHIATRICALLY DISABLED PERSON NEEDS.

LINKAGE, COORDINATION, ADVOCACY FUNCTIONS

1. How are patient/clients linked to services? ____________________

   Does this include information and referral? ____________________

   familiarizing client with community and resources? ____________________

   rehabilitation referrals which specify patient/client and providers roles and desired outcome? ____________________

   individual advocacy for access to services and resources? ____________________

   other? ____________________

2. Are ther active on-going linkages (e.g., joint planning,routine contact joint service delivery) among agencies in the area including:

   mental health agencies? ____________________

   housing authority? ____________________

   private landlords? ____________________

   health agencies ____________________

   social service agencies ____________________

   community organizations/groups ____________________

   transportation ____________________

   educational programs ____________________ vocational programs ____________________

psychosocial programs ____________________

recreational resources ____________________

crisis services ____________________

legal services ____________________

other ____________________

____

3. Is the agency/service area significantly involved with interagency coordination:
at the individual client level? ____________________

at the local systems level? ____________________

4. Is there an agency or staff member that assumes a leadership role in facilitating coordination? ____________________

____

5. Are there cooperative agreements:
on an interagency level? ____________________

6. Is there ongoing intensive work among providers to ensure continuity and coordination? ____________________

____

Source: Desisto, M.J. & Ridgeway, P., Community Systems Workbook, 1986.

assessing both the coherence of the agency's program and its consistency with best practices in psychiatric rehabilitation. A fee is charged by the Center to conduct the evaluation.

Implementation and Analysis. We recommend that program administrators approach program practice evaluation from multiple perspectives. It also is suggested strongly that board members, staff and clients be involved in the assessments described. Finally, it is suggested that such reviews occur at least once per year.

Program Connectedness

Background. In evaluating psychosocial rehabilitation services, the importance of system variables and system impacts has been widely recognized (Carling, 1984; Tessler and Goldman, 1982). System level analysis is particularly important in this sphere of mental health because only through such assessments can the complexity of the system components be captured, the "brokering" role of psychosocial rehabilitation be illuminated, and the agency's relationship to the community that it serves be explored.

In spite of its significance there has been little empirical work conducted in this area, partly because of the conceptual and methodological problems in pursuing system level research. For instance, service systems are difficult to define because boundaries are not necessarily clear cut. Furthermore, service systems may have vertical (hierarchical) relationships; therefore, the level or levels must be delineated before measurement can begin.

Bachrach has pointed out that indigenous community support systems, or "organic" systems, are particularly difficult to evaluate or make generalizations about because of the idiosyncratic nature of their structures and operations (Bachrach, 1982). CSP systems, are based on ten system components and specified formal linkages, have greater potential for systematic study. But even these "synthesized" service systems have tended to emphasize discrete programs rather than service linkages. The result has been a lack of system level data to analyze. Thus, causal relationships between system level variables and impacts on clients and on the larger system remain elusive.

Despite the conceptual difficulties and attendant methodological problems in measuring system variables and their impacts, several researchers have developed conceptual approaches for analyzing systems and several have applied them to CSP initiatives or other psychosocial rehabilitation models. Morrissey, Tausig & Lindsey (1985) has analyzed a hypothetical community support system, using his paradigm for exploring organizational linkages. The basic procedure is to define system boundaries, to collect data from key informants at as many levels of the organization as possible, and to use sociometric techniques or statistical clustering to analyze the data. The units of analysis are pairs of organizations.

Fein and Applegate (1982) conducted an empirical analysis of community support systems at the local level. For each CSP component, they identified provider agencies and categorized the quality of the relationships between each pair of providers.

Another conceptual approach to system level measurement has been "continuity of care." Using the client as the unit of analysis, researchers have traced clients' movements through the system over a period of time (Bass and Windle, 1973; Tessler, Willis, and Gubman, 1986), thus making discontinuities apparent. However, it must be noted that not all discontinuities can be attributed to gaps in the system or to poor communication between services. Clients themselves sometimes may elect not to follow through on recommended services. The concept of continuity of care, as measured by client utilization of recommended services, is only partially useful in obtaining a measure of system linkages.

Approach. Two key ingredients in psychosocial rehabilitation programs are programs' interconnectedness with other human services and the brokering function that they play on behalf of their clients. In their approach to the provision of services these programs tend to be multi faceted as opposed to unidimensional. The first issue to consider is the extent to which an agency has developed adequate connections with generic housing, income maintenance, employment, and other relevant generic and specialized human services. As persons with chronic mental illness have multiple needs, the quality of interagency linkages is crucial to successful client outcomes. Some of the methods for assessing the presence and efficacy of interagency relationships, which were described above, are extremely complex and not necessarily geared to an exploration of one agency's network. A more direct way to determine whether such linkages are in place is to assess client outcomes and the extent to which agency clients have been successful in securing needed generic services. The techniques described below involve both key informant interviews and self/assessment mechanisms.

Instrumentation. Agency staff or members of the agency's board of directors can conduct key informant interviews with the relevant generic agencies in the agency's community as one approach to determining the intensity and utility of interagency linkages. Interviews should be based on a structured inquiry guide that is focused generally on the quality and consistency of interagency connections. Agencies that might make up the program's extended network of contacts include the following:

- community mental health center;
- state hospital or county general hospital;
- private psychiatric hospital;
- medical facility;
- private therapists;
- public health or visiting nurse;
- local welfare department;
- local housing authority;
- vocational rehabilitation;
- local school system;
- Social Security Disability Determination Service;
- alcohol or drug abuse program;
- clergy/church groups;
- legal services;
- police and law enforcement;

- developmental disabilities and/or mental retardation agency;
- transitional and group residential services;
- sheltered workshop;
- mental health advocacy groups;
- private volunteer organizations; and
- other community agencies.

Understanding the nature of interagency relationships requires a set of categories. The following taxonomy was developed by Fein and Applegate to review the nature of interagency relationships among community support services and other agencies in Iowa (1982).

1. Case management (CSS case managers consistently are involved in securing, coordinating or facilitating a particular service with the provider agency, on behalf of the client);
2. Collaboration (CSS staff consistently are involved in joint staffings, planning meetings, consultation with provider agency with regard to clients or CSS program);
3. Referral (CSS staff refer client to provider agency or provide information on agency person or resources);
4. No linkage exists.

Prior to conducting interviews with agencies in the network, staff should determine the nature of the relationship between relevant agencies as they see it. Agencies in the network should be asked to characterize their relationship with the program using the same categories. This should make it possible to validate the staff perceptions regarding the nature of their relationships with other community agencies. Additional questions can be asked, and responses can be elicited using a five point scale (1=very good, 2=good, 3=medicore, 4=fair, 5=unsatisfactory):

> Please rate the nature of the information provided by the psychosocial rehabilitation program to facilitate referrals/collaboration, etc.;
>
> Please rate the level of knowledge of your program among staff you deal with from the psychosocial rehabilitation program;
>
> Please rate the frequency of your contacts with the psychosocial rehabilitation program;
>
> Please rate the appropriateness of the referrals made to your agency by the psychosocial rehabilitation program;
>
> Please describe the ways in which existing relationships can be improved;

Additional questions that are based on the particular circumstances surrounding the network of relationships also can be developed. The important thing is to cast the net fairly broadly and to evaluate the connections on a regular basis.

Another means of testing the viability of interagency linkages is through a self assessment process that proposes a series of problem scenarios involving various interagency activities. In a questionnaire developed as part of a two part exploration of the interagency relationships between mental health and vocational rehabilitation agencies and the connection between such relationships and positive vocational training outcomes, Woy and Dellario exemplified this problem solving technique. It was designed to be administered by a third party, but the problem statements also can serve as a self assessment exercise. The ratings after each problem, instead of coming from the interviewer, can be derived from a group consensus. Exhibit 7 reproduces the Interorganization Conditions portion of the Woy and Dellario instrument. Although this particular tool is aimed at vocational rehabilitation and mental health agencies, the problem statements can be tailored to fit other agency relationships.

Match to Need

In a perfect service system one could expect complete congruence between services needed and those received. In the real world, however, this occurs only sometimes. Numerous factors undermine the agency's ability to provide services needed by specific clients -- eligibility criteria thwart case managers' efforts to secure needed services, some services such as housing are chronically undersupplied, many clients require services that cut across the boundaries of numerous agencies, and sometimes clients refuse to participate in services that case managers recommend.

The goal of improving the degree of congruence between service needs and services received remains a reasonable one. Reducing the gap between services needed and services received is a key indicant of system responsiveness and maturity.

Instrumentation and Approach. The service record described in an earlier section (Exhibit 2) illustrates one way of collecting information to assess the degree to which clients are receiving needed services. Case managers record the number of units of each service received over a specified time interval (column two on this service record). Data from this column can then be compared with the service need information described

EXHIBIT 7

INTERAGENCY INQUIRY GUIDE

Agency ____________
Respondent____________
Rater ____________

I. Interorganizational Conditions

A. Communications

Problem: 1. The (VR/MH) requires information about one of your clients. Describe the procedure by which you share client information with (VR/MH).

Issue: How well do the agencies share client information? Rating:

very well	well	fair	poorly	very poorly
1	2	3	4	5

I. Interorganizational Conditions

A. Communications

Problem: 2. The (VR/MH) wishes to make a client referral to your agency. Describe the procedure by which the client referral is made.

Issue: How well do the agencies perform with respect to client referral? Rating:

very well	well	fair	poorly	very poorly
1	2	3	4	5

I. Interorganizational Conditions

A. Communications

Problem: 3. The (VR/MH) finds that they are able to offer a service complimentary to yours. Describe the procedure by which that service is coordinated with yours.

Issue: How well do the agencies coordinate services? Rating:

very well	well	fair	poorly	very poorly
1	2	3	4	5

Interorganizational Conditions

B. Decision-making

Problem: 4. You and your counterpart at (VR/MH) must decide on what services for a particular client should be provided by each agency. Describe the procedure by which this decision is made.

Issue: How well do the agencies delegate responsibility for service delivery? Rating:

very well	well	fair	poorly	very poorly
1	2	3	4	5

I. Interorganizational Conditions

B. Decision-making

Problem: 5. You and the (VR/MH) are preparing a joint conference for working with a particular client. Describe your input into this process.

Issue: How well do the agencies coordinate activities? Rating:

very well	well	fair	poorly	very poorly
1	2	3	4	5

I. Interorganizational Conditions

B. Decision-making

Problem: 6. The (VR/MH) is unable to live up to one of the preconditons of your linkage. Describe the procedures by which meeting these preconditions are monitored and corrected.

Issue: How well do the agencies conduct fence-mending/peacemaking activities? Rating:

very well	well	fair	poorly	very poorly
1	2	3	4	5

I. Interorganizational Conditions

C. Resources

Problem: 7. You find that the (VR/MH) is experiencing a financial crisis and requires a change in case planning. Describe the procedures by which your agency responds to this situation.

Issue: How well so these agencies exhibit flexibility of response to each other's problems? Rating:

very well	well	fair	poorly	very poorly
1	2	3	4	5

II. Intraorganizational Conditions

A. Communications

Problem: 8. Some information about a new intra-agency service to clients must be transmitted to members of your staff. Describe the procedure by which this information is transmitted.

Issue: How well does this agency demonstrate intra-organizational communication? Rating:

very well	well	fair	poorly	very poorly
1	2	3	4	5

II. Intraorganizational Conditions

A. Commmunications

Problem: 9. A potential client wishes to learn about the services provided by your agency. Describe the procedures by which such information is communicated.

Issue: How well does this agency conduct outreach and public relations concerning its services? Rating:

very well	well	fair	poorly	very poorly
1	2	3	4	5

Source: Woy, J.R. & Dellaroi, D.J., Issues in the Linkage and Intergration of Treatment and Rehabilitation Services for Chronically Mentally Ill Persons, undated.

earlier. Two levels of analysis are possible here. At the most basic level, clients can be scored according to whether they received any amount of each needed service. A more detailed level of analysis would involve a comparison of the amount of each service needed and received.. Differences in either direction (i.e., less service or more service) would be worth noting. If clients are routinely receiving fewer units of service than case managers prescribe, this might suggest that the program's capacity needs to be increased or interagency linkages improved. A less frequent outcome is when clients are receiving more units of service than prescribed. This might suggest that the program is fostering dependency or, alternatively, that a less appropriate service is being used because the more appropriate service is unavailable.

IV. OUTPUT EVALUATION

Output evaluation should be the third area added to a comprehensive strategy for assessing psychosocial rehabilitation programs. Results regarding this dimension will assist program administrators to assess the health of their agency through a variety of efficiency measures.

Productivity Evaluation

This form of cost-related evaluation addresses the question of whether the level of effort or service produced, relative to the amount of resources expended (costs) is reasonable. Productivity is measured using a unit cost index that includes a measure of cost and a measure of output. In the case of psychosocial rehabilitation services, the costs that would be indicated are those of the program overall or by individual service. Productivity evaluations almost always are done comparatively in order to provide decision makers with a sufficient number of referents for judging the agency's relative productivity. For this reason, it is important that the measures of both outputs and costs are such that they can be applied consistently from agency to agency.

In any evaluation of agency productivity, there should be three components: (1) the identification of agency and/or service specific costs, (2) the analysis of unit costs, and 3) the analysis of unit costs as a function of organizational and client variables.

Cost evaluation involves the assessment of the costs of producing psychosocial rehabilitation services. Depending on the type of evaluation, costs may be defined in two ways: narrowly, to include only those actual financial outlays associated with producing the psychosocial rehabilitation services, or more broadly, to represent that set of opportunity costs and social costs that is associated with the provision of these services. The following sections include a discussion of cost finding as well as cost function analysis.

Cost Finding.

- Approach

A definition of the costs associated with psychosocial rehabilitation agencies or programs is prerequisite to an evaluation of them. Of primary concern are psychosocial rehabilitation agency accounting costs, which represent the financial outlays involved in producing psychosocial rehabilitation services.

As does any enterprise, psychosocial rehabilitation agencie record expenditures by object (e.g., salaries, fringe benefits, supplies, etc.), record revenues by source (e.g., Title XIX, state general funds, etc), and prepare periodic income and expenditure statements and balance sheets. These agency level data generally are sufficient to compute the necessary indicators for evaluating an agency's financial condition as explained in a previous section.

On the other hand, identifying the total costs by service within an agency in order to evaluate its relative productivity in producing particular services can be a more demanding task.

This is especially true if the agency does not have a management information system that organizes costs by service.

Sorensen and Phipps (1975), and Sorenson and Newman (1985), provide well written guidelines on how to design management information systems that support thoroughgoing, service specific cost finding procedures. These references should be consulted by agencies interested in developing such systems.

- Implementation and Analysis

The following guidelines are intended for those evaluators of psychosocial rehabilitation programs and service costs who must conduct ad hoc cost finding efforts as part of an evaluation of an agency's productivity, or of program cost/benefits or cost/effectiveness. Even where agencies possess such management information systems and cost finding procedures, the evaluator still may find it necessary to superimpose his or her own procedures in order to assure that the cost finding is uniform across agencies.

The procedure is divided into nine steps, the first six of which are sufficient to identify the total agency level or program costs. Steps six through nine are necessary to estimate the total cost by service.

First, list the total agency expenditures by object for the period of interest. List the categories (objects) of expenditure down the left column. Across the top list the services of interest within the agency. Use footnotes to identify costs estimated for contributed items, to indicate how facility and equipment expenditures were adjusted (if at all), and to explain the bases (e.g., square feet of occupied space, hours of direct staff time) upon which the indirect costs were allocated across different services offered (direct cost centers). An illustrative worksheet is shown in Exhibit 8.

The personnel segment of the list of expenditures should be broken down by position, and fringe benefits should be shown separately. Other categories of expenditure should be broken down as far as the evaluator finds necessary for the purposes of the cost evaluation.

Second, identify and add in any other expenditures that do not appear on the agency's books because they are covered under the budgets of related agencies (e.g., utility costs, transportation costs, insurance costs, pension fund costs, etc.).

Third, identify and deduct any items of expenditure for activities and services that are of no material benefit to psychosocial rehabilitation agency clients (e.g., general research activities the potential benefits of which extend largely to clients other than those in the agency, and training of interns most of whom will leave the agency following their period of intership).

Fourth, adjust the facility and equipment items of expenditure (optional). Some agencies simply may lease facilities and equipment, other agencies may expense all such purchases in the year of purchase, others may amortize these facilities and equipment over their useful lives, others (some public agencies) may not expense them at all. Unless these

EXHIBIT 8

ILLUSTRATIVE WORKSHEET FOR ESTIMATING COSTS

ITEM OF EXPENDITURE:	ALL:			COST CENTER:			
				Service A		Service B	
	Total	Indirect	Direct	Indirect	Direct	Indirect	Direct
Personnel							
Salaries & Wages							
Fringe & Benefits							
Facilities & Equipment							
Unadjusted							
Adjusted							
Purchased Svcs							
Utilities							
Supplies & Materials							
Other							
Total							

a Contributed (use to label contributed items)
b Adjusted (explain the basis for adjustment)
c,d,...n Allocation Base (use to identify base used to allocate indirect cost e.g. salaries, square feet, direct costs, etc.)

reported expenditures are made reasonably uniform, they can skew comparative cost evaluations. If the object of the cost evaluation is to assess actual financial outlays, then comparability is not an issue and such an adjustment would not be necessary. A fairly common method for uniformly expensing facilities and equipment is to identify what it would cost to lease the facilities and items of equipment at current market rates, and to substitute the lease rates for the actual costs.

Fifth, identify and show separately the market value of contributed goods and volunteer services that are not reflected on the books. Counting these costs will result in cost figures that exceed actual (out of pocket) costs. Ignoring these costs will result in cost figures under valuing the resources employed in providing psychosocial rehabilitation services. In either case, these costs should be identified and their treatment explained in any evaluation of agency costs.

Sixth, sum the total program costs.

Seventh, for each item of expense, estimate the portion of the expense that is direct and indirect. The direct portion represents that portion of the costs identified specifically with a particular service. The indirect portion is that which is incurred to the joint benefit of a number of services and thus must be apportioned among them.

Eighth, assign the direct costs and allocate the indirect costs among the services. The indirect costs should be allocated on the basis of some common denominator (e.g., number of clients, direct costs, square feet of space) that fairly represents the utilization of the resources covered in the indirect cost figures. For example, a reasonable basis for allocating the facility maintenance and repair costs among services would be the square feet of space occupied by each service area. An important principle of cost estimation is to devote attention to any particular category of expense according to the proportion of the total expenditures reflected by that component. Because psychosocial rehabilitation agencies are labor intensive, with personnel generally representing from 65% to 85% of the total costs, a procedure for tracing staff time over the period of interest to each of the services is central to any cost finding procedure. Unfortunately, the most accurate procedures for assigning personnel time and associated costs by program or service are also the most intrusive and expensive -- independent monitoring and the institution of a staff time keeping system. Simply asking staff to break down how they spend their time in retrospect is a poor substitute, and can lead to unreliable results (Ashbaugh and Allard, 1984).

Unit cost figures are simply found by dividing the total agency- or service-specific costs for a period identified by the number of units of output provided during that period. Three types of units (output measures) might be employed: (1) cost per case or episode, (2) cost per time interval (day, month, year), and (3) cost per period of service. For long term services, from which the client is not expected to graduate and of which the volume per client is not considered to be a prime indicator of the efficiency of the program, the cost per time interval is probably the most appropriate measure. However, the cost per period of service may be the most appropriate measure for short term services, for which the volume per client is not considered to be a prime indicator of service efficiency. For other programs, in which the volume of services per client and/or the time spent in the program are considered to be prime indicators of efficiency, cost per case or episode is probably the most apt measure. For most psychosocial rehabilitation agencies, some combination of these measures is probably appropriate.

Cost Function Analysis.

- Background.

The analysis of the variation in unit costs relative to variations in the programmatic, organizational and client factors (which combine to represent the program or service) commonly is termed "cost function analysis" or "production function analysis." At the base of cost function evaluation lies the concept that a given service can be produced alternatively by more than one set of resources (inputs). Moreover, the same service can be produced by a variety of different techniques for any set of resources. In other words, resources and techniques are substitutes in producing any combination of services.

The purpose of such analyses is to identify those factors that explain the differences found in unit costs as part of the comparative analysis (e.g., program size, ownership (public/private), staff to client ratios, number of years in operation, average staff tenure, etc.). Cost function analyses are an essential part of any comparative cost evaluation. After all, cost comparisons are useful only to the extent that one is able to understand what they represent. To point up differences in psychosocial rehabilitation costs among agencies is of little help to decision makers unless they also understand why these costs vary, whether the reasons seem justifiable, and whether they can do anything about it.

- Approach

If there are a large number of agencies subject to evaluation, multiple regression analysis can be used to identify client, programmatic and organizational variables (independent variables) that show a high (significant) degree of association with unit costs. One might employ a simultaneous regression procedure that forces the inclusion of all independent variables (found in earlier research to be predictors of unit cost) into the regression equation. Or, one might employ a stepwise regression procedure that orders the inclusion of independent variables according to their part correlation with the unit cost variables. In the latter, only those variables that significantly add to the predictive power of the linear regression equation become part of the final equation.

- Methodological Considerations

Irrespective of the number of agencies under evaluation, the evaluator should identify those agencies that show the highest and lowest unit costs in the comparative cost analysis. Through interviews with key programmatic and fiscal informants and through the comparative analysis of these variables, he or she also should attempt to identify those variables that seem to account for the relatively high or low unit costs. The choice of extremes allows one more readily to uncover explanatory variables than would be the case if one were to select providers randomly. Because psychosocial rehabilitation programs are labor intensive, the first variables to be explored should be those relating to staff salaries, fringe benefits and staff mix (type of staff). Other factors that tend to differentiate high and low cost programs are differences in the amount of contributed resources and the type of clients served (e.g., acute versus chronic, old versus young).

Staff Productivity

Background. The productivity of an agency's staff is inextricably linked to the way in which the agency is structured, the procedures that are employed, and the level of support that is provided. In the monograph, *Assessing and Improving the Performan of Psychosocial Rehbilitation Staff*, Friday and McPheeters (1985) note that there are several strategies available to psychosocial rehabilitation programs to improve productivity:

- clarify program philosophies and goals;
- improve organizational structures and procedures;
- improve utilization of human resources;
- modify clinical technologies;
- improve organizational climate;
- improve scheduling and use of time; and

- improve use of facilities and support services.

Approach. Before implementing these strategies, however, psychosocial rehabilitation administrators first must evaluate their programs in each of these areas. Exhibit 9, taken from the Friday and McPheeters report, provides some sample questions in each of the above areas.

EXHIBIT 9

STAFF PRODUCTIVITY

Program Philosophies and Goals

--It shall be the policy of the program to serve as many clients as possible with a basically adequate quality of service, rather than only a few clients with the highest quality of service.

--It shalll be the policy of the program to use those clinical technologies which are least consuming of time and staff resources in obtaining results for clients.

--It shall be the policy of the program to perform only the diagnostic and rehabilitation procedures which are substantially and significantly to individual client needs (not "routine" or tangential procedures and services).

--It shall be the philosophy of the program to focus on improving the social and vocational functioning of clients rather than on their interpersonal functioning.

--It shall be the philosophy of the program to particularly address those client needs and behaviors which, if not addressed, will very likely result in the client being rehospitalized.

Organizational Structures and Procedures

--Do the organization's structure and procedure create delays in transferring clients or clinical information between services or units?

--Are there delays in implementing action because of requirements for decision and approval by too many individuals and team or staff meetings?

--Are there "standard operating procedures" to which all clients are subjected whether they are needed or not?

--Are responsibilities and authority sufficiently clear so that staff members or team leaders can respond readily to client needs and take apprOriate actions?

Utilization of Human Resources

-- Are clinical staff assigned to be responsible for the overall care of individual clients or only to discrete activities of their professions?

-- Are teams organized and used so that decisions can be easily made?

-- Is considerable staff time spent in meetings (e.g., quality assurance commitees, planning and program evaluation committees)? These areas require staff participation, but often committees can function more expeditously with a smalll number of staff, thus freeing clinicians for client work.

-- Is supervision adequate to identify and remedy problems, such as excessive absenteeism, poor work habits, or clinical deficiencies?

--Are paraprofessionals used as client care workers or only as aides to professionals?

Modified Clinical Technologies

--Could behavioral approaches be used to shorten the rehabilitaion time and improve the results?

--Can group approaches be used for some of the education and counseling of clients, and thus increase the numbers of clients served?

-- Can short-form assessment procedures suffice for most clients instead of the traditonal full-scale instruments and procedures?

Improved Organizational Climate

--Is there organizational instability as a result of frequent reorganizations or leadership changes?

-- Is morale poor as a result of low pay or bureaucratic rigidities?

-- Are there communication problems that leave staff feeling unsure or that nobody cares?

-- Are there incentive and reward systems for outstanding performance?

Scheduling and Use of Time

--Are there provisions for scheduling alternate client for times when clients are late or cancel their appointments?

--Are staff conferences, training sessions, etc., held to the minimum time necesssary and at times when they are least likely to interfere with client needs?

--Are working hours, lunch hours, etc., scheduled so that there is maximum time available for staff to work with clients?

--Are the work and data scheduled so that they flow from one staff member to another without undue delays?

--Do staff members have adequate skills in personal time management?

Use of Facilities and Support Services

--Are team members located so that they can interact easily?

--Are there support staff to assist in record keeping, monitoring cases and appointments, and preparing reports?

--Are automation systems used to streamline staff activity?

--Are statistical reporting forms simplified for staff use, and is information fed back to them promptly?

Friday, J.C. & McPheeters, H.l., Assessing and Improving the Performance of Psychosocial Rehabilitaion Staff, 1985.

V. OUTCOME EVALUATION

Evaluating outcomes is at the crux of program evaluation. Continued social, political, and financial support depend ultimately on the program's ability to demonstrate that it has made a difference in the lives of the client's it serves.

In this section a few of the many possible outcome dimensions are discussed. In thinking about outcome research, one tends to think first of service effectiveness. However, service acceptability is also a relevant dimension. Therefore, we have included in this section discussions of client and family satisfaction with services.

The section ends with a review of client outcome research focusing on community adjustment, level of functioning and quality of life.

Client Satisfaction.

Background. Given the primacy of client autonomy among psychosocial goals, it is somewhat surprising that client satisfaction studies are fairly rare in the literature on psychosocial programs. One exception is Hill House in Cleveland, Ohio, which has intentionaally set out to assess client satisfaction and has also included clients themselves in the design of the evaluation process. Hill House has formed a special program -- Client Oriented Program Evaluation, or COPE -- in which a group of volunteer clients design evaluation instruments, collect data, interpret results and implement recommendations. Volunteers are paid a small stipend. To date, they have developed a needs assessment form and a client status instrument, and have assessed client satisfaction with specific Hill House services.

Hill House has identified the following as advantages of client participation in the execution of client satisfaction surveys: 1) higher face validity of client designed instruments; 2) greater integration of program evaluation into other agency activities; 3) greater openness on the part of respondents to client designed items; and 4) more serious consideration of findings by planners and practitioners (Tanaka, et al., 1984). The use of clients as evaluators -- in addition to respondents -- is discussed in the concluding chapter.

Other examples of client satisfaction instruments which attempt to capture the client's service experience as well as the impact that services might have had on his or her life include the "Member Satisfaction Questionnaire" prepared by Fellowship House (December 1986) and the "Client Satisfaction Questionnaire" (Attkisson and Pascoe, 1983). Both of these instruments include specific questions both about the performance of the agency as well as the influence that the service had on the client's return to social and vocational functioning.

Approach. Client surveys have been used to solicit the opinions of service consumers in a variety of health and human services areas. Client surveys may be used alone or in conjunction with other monitoring or evaluation techniques as part of a larger evaluation plan. Data may be collected through personal interviews, telephone surveys, or self-administered questionnaires. Such evaluation activities, however, are relatively recent, especially in mental health. Evaluation has been focused primarily on the professional and technical aspects of service. Studies have been conducted by professionals and only rarely has client input been considered.

This situation has changed considerably during the past decade and client surveys are gaining increased credibility. This new interest in client attitudes reflects increased consumer activism (through the formation of political and self help groups) and an intensified demand for accountability from those who provide services. It is also a recognition that notions of program effectiveness should be multifaceted and defined by a range of interests including those of the recipients of service.

In addition to assessing the level of satisfaction with services, client surveys also can elicit information relevant to staff and agency performance, quality of life and service outcomes. This is discussed in other sections of the monograph. Finally, the use of client satisfaction assessments provides a validation of the agency's mission; it is a way of expressing to persons who use services that they are equal participants in the service process.

Assumptions and Methodological Considerations. The design of any client survey should conform to the general principles of sound research design. A number of specific technical considerations complicate this design. These include maximizing the reliability and validity of data obtained from clients, and establishing norms which make the data from client surveys more easily interpreted.

- **Reliability and Validity**

The literature on client satisfaction suggests that data from client surveys may be especially vulnerable to problems of reliability and validity. The former is defined as the consistency of a measure over repeated applications; the latter as the degree to which an item actually measures the concept it is intended to measure. There are a number of sources of error in client surveys that can reduce considerably the reliability and validity of the measurement process. But there are strategies that appear to improve the reliability of data -- specifically the use of multi-item rather than single item or global measures.

The validity of measures used in client surveys is threatened by the tendency of respondents to try to give socially acceptable responses to questions. In their efforts to conform to widely accepted beliefs or attitudes, respondents sometimes distort their true sentiments. This problem affects all forms of survey research; however, it is especially troublesome in client surveys. Since clients frequently are dependent on the service provider in a variety of ways, they may be reluctant to express sentiments that are critical of the service provider. They may feel that negative comments could result in the withholding of services or a reduction of effort exerted on their behalf. If a client feels constraints on his ability to express concerns about a service program or progress in the program, the validity of resulting data is suspect.

Fortunately, there are a number of strategies that make clients less reluctant to provide valid feedback. Perhaps the most obvious is to assure respondents of the confidentiality and anonymity of their responses. If clients know that all data are to be aggregated and that no personally identifying information will be released, they may feel more comfortable in expressing their true sentiments. These assurances typically are provided in an introductory statement at the beginning of a questionnaire or in the introductory comments made by an interviewer.

In the case of client interviews, measurement validity also can be improved by having a person other than the client's primary service provider conduct the interview. It is almost always bad practice to have an individual who is associated closely with the treatment or service process asking clients for feedback concerning the program. If the program has a research staff, these individuals might be appropriate interviewers. If not, clerical staff can be recruited for the task. Another approach is that of training volunteers, board members or other clients to pose questions.

Simlarly threatening to measurement validity is, "acquiescent response set" (ARS), or the tendency of respondents to agree with statements on a questionnaire or interview form regardless of content. Once again, this is a problem for survey research generally, but it is probably more pronounced in client surveys. Strategies to minimize the effects of ARS center on the instrument design. For instance, where it is possible, questions eliciting a yes/no response should be avoided. Where this is not possible, check items should be inserted into the questionnaire or interview schedule to insure that acquiescing is not happening (e.g., paired questions, such as "are you usually happy?"; "are you usually sad?"). Also, it is wise to ask questions about the instrumental character of the services received, such as, "in what ways has this service expanded your opportunities to participate in the activities of your community?"

- Developing Norms

The ability to compare scores for the same organization over time or to compare scores from similar agencies enhances most evaluation studies. This is especially true of studies that use client surveys to obtain feedback on satisfaction with services. Since client satisfaction surveys typically tend to show fairly high rates of satisfaction, these scores by themselves do not always provide a lot of information. By comparing these scores with available norms, however, it becomes somewhat easier to interpret small variations. In the case of psychosocial rehabilitation programs, the norms most likely will be derived from previous applications of the survey. But it may be possible to standardize client satisfaction surveys within a region or within a state, thus generating norms across programs.

Specific Instruments. Exhibit 10, "Client Evaluation of Services" (Larsen, Attkisson, Hargreaves, & Nguyen, 1979), is an example of a simple and straightforward instrument, easy to

EXHIBIT 10

CLIENT EVALUATION OF SERVICES

Please help us improve our program by answering some questions about the services you have received. We are interested in your honest opinion, whether they are positive or negative. Please answer all of the questions. We also welcome your comments and suggestions. Thank you very much, we really appreciate your help.

CIRCLE YOUR ANSWER

1. How would you rate the quality of service you have received?

4	3	2	1
Excellent	Good	Fair	Poor

2. Did you get the kind of service you wanted?

1	2	3	4
No, definitely not	No, not really	Yes, generally	Yes, definitely

3. To what extent has our program met your needs?

4	3	2	1
Almost all of my needs are met	Most of my needs have been met	Only a few of my needs are met	None of my needs are met

4. If a friend were in need of similiar help, would you recommend our program to him or her?

1	2	3	4
No, definitely not	No, I don't think so	Yes, I think so	Yes, definitely

5. How satisfied are you with the amount of help you have received?

1	2	3	4
Quite dissatisfied	Indifferent or mildly dissatisfied	Mostly satisfied	Very satisfied

6. Have the services you received helped you to deal more effectively with your problem?

4	3	2	1
Yes helped a great deal	Yes helped somewhat	No really didn't help	No made problems worse

7. In an overall, general sense, how satisfied are you with the service you have received?

4	3	2	1
Very satisfied	Mostly satisfied	Indifferent or mildly dissatisfied	Quite dissatisfied

8. If you were to seek help again, would you come back to our program?

1	2	3	4
No definitely not	No I don't think so	Yes I think so	Yes definitely

Source: Larsen, Attkisson, Hargreaves, & Nguyen, Service Evaluation Questionnaire, 1979.

administer and score. It has multiple items and it avoids yes/no responses. Depending on the nature of the particular program, one may want to ask specific questions about service components such as residential and vocational supports. One also may want to ask more open ended questions about the ways in which the program contributed to personal autonomy and independence, and the extent to which staff displayed respect for individual dignity.

Another instrument which may prove useful was developed by Fellowship House in Florida. Their client survey asks general questions about barriers to service, membership and transportation issues, comfort with existing communication networks, discrimination, and the general effect that the program has had on the lives of the consumers. Specific questions also are asked about the social, residential and vocational components of the programs. Included in the appendix is the full 55 item questionnaire with the 1985 results of one set of norms for purposes of comparison. Though the Fellowship House questionnaire is long, it does include more material on program related satisfaction, such as the treatment clients received from staff and the extent to which the program has facilitated integration.

Implementation/Analysis. Client satisfaction surveys should be conducted consistently and systematically on a schedule that depends on program need. As noted earlier, they can be administered in a variety of ways: using research or clerical staff, asking clients to provide responses in writing, using volunteers or board members to ask questions, or asking other clients to help with the process. The latter technique probably would ensure a more frank and open response. The key is to assure clients that their responses will be confidential and that there will be no repurcussions to critical answers.

Family Satisfaction

Background. The search of the literature revealed few evaluation studies in which families served as respondents. An excellent review of these articles can be found in a paper by Fisher, Benson and Tessler (1987).

The studies that have been conducted suggest that families in the caregiver role are dissatisfied with the kinds of services that they are offered (Hatfield, Fierstein, and Johnson, 1982). Schulberg and Bromet (1981) emphasize the importance of assessing the satisfaction of families as part of an overall evaluation scheme: "Alleviating family burden through an increased range of services in more hospitable agencies is thus a major goal of community support systems. Assessments are needed of whether this target population has benefited."

Among the studies which were found, three stood out. The first, by Hatfield, Fierstein and Johnson (1982), was based on a survey of members of self-help organizations of families of mentally ill persons in nine states. Respondents were asked to provide demographic information, their goals for treatment, and the extent to which such treatment met those goals. The results strongly indicated that the families' needs were not being served by their current service arrangements. The study findings were compared in turn with various theories of family therapy to determine whether family goals were consistent with the goals as espoused by the field. In commenting on the lack of consonance between family and professional goals, the authors note: "Families are not asking for help for their own problems but rather for the unusual levels of knowledge and skill they need to effectively manage mental illness at home. Mental health professionals understand the need for training those who care for the mentally ill in settings other than the home; yet families' difficulties in management are ascribed to pathology and they are offered therapy."

Conducted by Levine and Spaniol (1985), the second study also involved a survey of members of self help groups composed of family members of persons with mental illness. The purpose of the survey was to secure information on the extent of family involvement in facilitating and/or providing services to persons with mental illness. The authors commented on the relative benefits and drawbacks of family sponsored community services.

An additional study by McLean, Greer, Scott and Beck (1982), provides an evaluation of a support and education group for families of persons with mental illness whose relatives had been institutionalized at a state hospital in Massachusetts. The article describes the level of staff involvement, the nature of the training provided to parents, the goals expressed by family members, and the ultimate establishment of a parent self-help group outside of the hospital. All three articles, indicate a strong desire among family members for concrete information about their mentally ill family member's condition and the treatments and medications available.

An article by Reiter and Plotkin (1985) describes a study in which family members assumed a far more active role. In this instance family members actually monitored conditions at a state hospital and monitoring reports were given to unit directors as feedback concerning needed improvements.

Clearly, additional evaluation is necessary to probe further into the areas of family satisfaction, family capacity building, and family services most likely to assist families to cope with the needs of their mentally ill family member. As noted earlier, it is also important to understand how family expectations differ from those of the client and in turn to use this information to design programs that seek to find a common ground of understanding.

Approach. As our literature review suggested, relatively little is known about the interactions of families and providers. One can speculate that this relationship could be a stressful one, given the level of emotional involvement and the strains inherent in caring for persons with chronic and serious mental illnesses.

Families are playing an increasingly important role in the community care of persons with chronic mental illness. We need to know more about how relationships between families and providers evolve and how service systems can enhance these relationships (Fisher, Benson, and Tessler, 1987). Some of this is basic research and should be conducted on a large scale. However, the individual program also has an interest in this issue since it bears directly on the welfare of clients and or successful program outcomes.

Before a program can begin to involve family members in evaluation and/or monitoring, decisions concerning the level of involvement need to be made. Involvement could range from having family members respond to satisfaction questionnaires to the more active role of monitoring service delivery. In the following section we discuss one way of initiaing family involvement in the evaulation process through a very brief family satisfaction questionnaire.

Assumptions and Methodological Considerations. Most of the methodological considerations which need to be addressed in a research plan to evaluate family satisfaction have already been discussed in the section on client satisfaction.

Evaluation strategies need to ensure that family respondents feel free to express honest opinions, without fear that critical comments will have negative repurcussions for their family members. Survey formats that promise anonymity can make respondents feel considerably freeer to express their concerns. Mail surveys that do not require names or other identifying information are a good example of such formats.

The problem of normative comparisons is particularly acute with respect to family satisfaction studies. Since so little has been published in the research literature, it is difficult for programs to compare their levels of satisfaction with those other similar programs. Also, since the satisfaction questionnaires should be completed anonymously, it is impossible to use respondents as their own controls, thus measuring changes in satisfaction levels over time.

In this case, however, the absence of norms is not a serious flaw, since the main purpose is to use the survey to identify incipient problems and stress while there still is time to launch remedial action.

Instrument. There are few instruments to choose from in the area of family satisfaction. One interesting approach has been developed by Hatfield (1987). It has been used by the Alliance for the Mentally Ill chapter in Montgomery County to assess family satisfaction. A slightly modified version of this instrument is attached as Exhibit 11.

The instrument differs from some of the more typical satisfaction instruments, which tend to look only at global assessments of service acceptability. It focuses on satisfaction with specific dimensions including:

- Appropriateness of expectations;
- Growth in independence from family;
- Care and supervision;
- Growth in living skills;
- Assessment of relative's satisfaction; and
- Provider/family relationships.

In addition to scaled questions, one might add some open ended questions which seem appropriate to the particular situation.

EXHIBIT 11

FAMILY SATISFACTION WITH COMMUNITY SEVICES

We are making a brief assessment of family satisfaction with Community Services. If your relative now uses these services or has done so in the past two years, please reply.

Community Services

Rate satisfaction with community services for your relative.

	LOW				HIGH
Appropriate level of expectation	1	2	3	4	5
Growth in independence from family	1	2	3	4	5
Care and supervision of relative	1	2	3	4	5
Growth and socialization and living skills	1	2	3	4	5
Your relative's satisfaction with living situation	1	2	3	4	5
Relationship of staff to family	1	2	3	4	5

Please explain any low ratings (ratings of 1 or 2):

Sign if you would like to discuss this questionnaire:

Name:______________________________

Address:____________________________

Phone:______________________________

Source: Hatfield, A., Alliance for the Mentally Ill, 1987.

Implementation/Analysis. We recommend that the family satisfaction data be collected through mail surveys. These surveys could be conducted annually; or if resources were sufficient and circumstances warranted more frequent administrations, every six months. The data can be used to identify potential trouble spots as well as to obtain a picture of overall relationships between families and the provider.

Client Outcomes

Background. This section contains a review of a sample of outcome evaluations drawn from the voluminous literature on outcome research that has emerged during the past two decades. Much of the work that has been done in this area is quite specialized and involves fairly sophisticated statistical analyses and modeling. It has advanced considerably our understanding of the effects of different kinds of treatment. However, it also has made the technology of outcome evaluation appear somewhat inaccessible to program directors who have limited resources to devote to research.

The purpose of this section on outcome is to suggest that research to date -- or at least some pieces of it -- can be made relevant to the program director or manager who is interested in feedback on how his/her program is doing, as opposed to general information on how psychosocial programs operate.

The studies reviewed here are just a sample of the available literature. Our intent is to illustrate the ways in which various indicators have been used to measure treatment outcomes. The outcome measures reviewed include rehospitalization, economic self-sufficiency, living arrangements, community adjustment or level of functioning, and quality of life. This section also contains a discussion of the possible types of normative comparisons that help one to interpret the findings from outcome evaluations.

Rehospitalization. Rehospitalization has been the most frequently used measure of success for community mental health programs. The use of rehospitalization as an outcome measure has been criticized lately for a variety of reasons. As Mosher and Keith (1980) have noted rehospitalization can be influenced by a number of system-related variables. In addition, hospitalization can mean a number of different things. For example, a hospitalization episode of a few days' duration primarily for medication review is very different from a hospitalization episode that lasts for several months. It clearly could be quite misleading to treat both episodes as similar.

Despite these caveats, rehospitalization is still a useful measure, particularly when it is used in conjunction with other outcome indicants. Relatively easy to measure, it also bears a relationship to the goals of most community based mental health programs.

Rehospitalization has been measured three ways in the research literature.. In its simplest form, rehospitalization can be treated as a simple dichotomized variable; clients are either reshospitalized during the study period or they are not.

Lamb and Goertzel (1972), and Mulkern et al. (1986) reported simple rehospitalization rates as one of several measures of success for community programs.

A second and somewhat more sophisticated approach involves an examination of the number of hospitalizations or the length of stay of each hospitalization during a specified time period. This allows one to get a somewhat clearer understanding of what each client's rehospitalizations mean. For example, Shedletsky and Voineskos (1976) presented data on the number of rehospitalizations. This allowed them to examine the "revolving door" phenomenon. Similarly, Dickey, et al. (1981) reported the amount of time clients had spent hospitalized during a study period and Smith (1975) reported the correlate of days hospitalized, and casting his data as percent of time spent in the community (i.e. not hospitalized or in any other institutional setting during a three year study period).

The third and best approach to analyzing rehospitalization data is exemplified by Radinsky, Rein, and Blanas (1978), who collected data on the number of rehospitalizations during the twelve month periods preceding and following enrollment in a community program. This allowed them to use the subjects as their own controls and to examine changes in the pattern of each individual's use of hospital care following treatment.

Economic Self-Sufficiency. A second variable which frequently has been used as an outcome indicant is economic self sufficiency. Many chronically mentally ill persons have virtually non-existent work histories and few skills that would serve them well in the work place. Recognizing the therapeutic value of work in and of itself, the meaning of work as an integral component of adult role performance, and the centrality of work in American culture, many community programs have developed vocational training programs or supported work models in their service programs. The Community Support Program, for example, has included vocational services as one of its core service components.

Economic self sufficiency has been conceptualized and measured with a number of different indicators. Like rehospitalization, the simplest measure is a dichotomized variable of working/not working (Solberg and Raschman 1980). Employment status is a useful variable because it is easy to measure and bears a clear relationship to program goals. The problem with this gross measure, however, is that competitive employment may be an unrealistic goal for many persons with chronic mental illness. Field and Yegge (1982) broadened this dimension, examining "productive activity" rather than simple employment status. This they defined as employment, homemaker duties, volunteer work, and formal employment training.

Another indicant of economic self sufficiency is welfare status. Some researchers (e.g., Auerbach and Pattison, 1976; Radinsky, Rein,and Blanas, 1978) have used the proportion of clients coming off welfare as an indicant of program effectiveness. Given the goal of most community programs to increase clients' ability to provide for their own economic needs, this is a reasonable outcome measure. But, in using this measure, one needs to be aware that simply coming off welfare may not necessarily indicate improvement in the client's ability to provide for him/herself. System level changes, such as the wave of eligibility redeterminations for SSI and SSDI in the early to mid 1980s, may influence the client's welfare status.

Living Arrangement. The client's living situation is a third indicator that is often used to evaluate the effectiveness of community programs. Most studies examining this topic have focused on hospital vs. community residence rather than the type of living situation in the community. However, the latter setting is a relevant outcome indicator, as most programs make implicit value judgments concerning the relative desirability of different types of settings. Such judgements should be enhanced by information from client satisfaction surveys regarding residential preferences and should be sensitive to individual circumstances.

One way of utilizing this variable is to describe the living situation of program clients at one point in time. Any number of schemes may be developed to categorize different settings.

A more detailed approach is to examine changes in living situation during a specified study period (Mulkern, et al., 1986). This allows one to assess the stability of clients' residential situations over time. Such an assessment, however, should be tempered by an understanding of the extent of movement among the general population and among particular age groups.

Level of Functioning/Community Adjustment. One of the most heavily researched outcome areas is client adjustment or functioning. The language used in various studies differs: some researchers refer to level of functioning, others to community adjustment, still others to psychosocial functioning. Most, however, are concerned with the client's ability to perform adult roles in the community and on the level of active symptomatology. This is obviously a wide area to explore. The diversity of methods used reflects not only the complexity of the concepts being measured, but also the lack of agreement on the best measurement techniques. Some of the issues that remain to be resolved include:

- Identification of the domains that are most useful in understanding community adjustment;
- Agreement on measures that capture these domains efficiently, reliably and validly;
- How best to measure change (whether to use raw change scores or some standardized change score that corrects for the individual's Time-I score); and
- Identifying and controlling extraneous variables which might mediate the relationship between treatment and outcome.

Despite these rather serious measurement problems, numerous studies have attempted to measure client functioning or adjustment. Most of these outcome studies have at least two things in common. The first is the use of a longitudinal approach to measurement; assessing functioning or adjustment at more than one point in time. Most employ a simple pre-test/ post-test design with two data points, one at program admission and a second at some later point. The second common element is the use of multiple measures of functioning or adjustment rather than a single measure. This enables the evaluator to deal more adequately with the complexity of the concept being measured and to explore the relationships among outcome dimensions themselves.

A full review of studies which have examined level of functioning or community adjustment is beyond the scope of this section. However, a description of a sample of such studies will provide a sense of the diversity of approaches. One of the earlier studies of the impact of psychosocial rehabilitation services on level of functioning was conducted by Wolkon, Karmen and Tanaka at Hill House (1971). Employing a modified control group experimental design, this study followed the progress of clients released to Hill House from three state hospitals. Three dimensions of role performance were assessed: 1) social participation, 2) instrumental role performance, and 3) affective or expressive role performance. Social participation included auch activities as church attendance, informalaorganizational involvement, and visits with friends. instrumental role aerformance included such family tasks as shopping and performing household chores. Affective role performance included the frequency with which specific topics were discussed by the client and his or her family and friends.

Stein, Test and Marx (1975) examined adjustment as part of their evaluation of the Training in Community Living (TCL) program. The dimensions they included were living situation, time in institutions, employment, social relationships, quality of environment, subjective satisfaction with life, and leisure time activities.

Ross, Menapace, and Teitelman (1981) examined psychosocial functioning in their evaluation of clients enrolled in the psychosocial program at Horizon House. They used an instrument entitled "Client Adjustment Rating Scale (CARS)." This instrument includes scales measuring nine domains: motivation, self-concept, family functioning, self-reliance, affect and mood, vocational/educational readiness, interpersonal relationships, personal maintenance, and community resources.

In a recently completed longitudinal study of clients enrolled in Community Support Programs, Mulkern, et al. (1986) examined changes in community adjustment using eight scales: acting out in the community, acting out at home, socializing with friends, community participation, community living skills, overall adjustment, grooming skills, and alcohol and drug problems.

The above examples are a cross section of studies that use a variety of multi dimensional measures to assess outcome. They are instructive because they attempt to deal with the complexity of outcome measurement. Many studies augment these multidimensional scales with global assessment measures. Economical to administer and analyze, such measures often provide good summary indications of level of functioning or changes in level of functioning. As Endicott et al. (1976) have noted:

> The most commonly used global rating scales are simple five or seven point scales with single word adjective anchor points without any cues or criteria to aid the rater. It is a testament to the power of global rating scales that even such simple scales have been demonstrated to be among the most powerful in detecting change. They cannot, of course,

supply the detailed information provided by multidimensional rating scales, but they have their obvious uses as summary statements.

One such scale is the Resource Associated Functional Level Scale (RAFLS) developed by Leff (1985). This is a seven-point ordinal rating scale that links social role functioning and behavior to level and type of services needed. This scale differs somewhat from other scales described in the literature; it includes an assessment of both service need and level of functioning. Additionally, most global scales described in the literature were developed for use with a wide range of client types with drastically different impairment levels. As a result, when such scales are used to assess persons with chronic mental illness, cases tend to be clustered at the bottom of the scale and the discriminating power of the instrument suffers. The RAFLS was developed specifically for persons with chronic mental illness and tends to spread cases somewhat more widely.

This brief review of outcome studies examining community functioning or adjustment suggests that there is a fair amount of overlap in the areas covered by different evaluators. There also are unique aspects to most of the studies. The variety of measures used provides rich coverage of this complex phenomenon; the studies cited provide good examples of how various measures can be integrated into a comprehensive outcome assessment.

Quality of Life. A final outcome dimension is quality of life. Unlike more traditional mental health programs that focus almost exclusively on symptom reduction and enhanced psychiatric status, psychosocial rehabilitation programs have broadened their focus, taking the improvement of clients' living circumstances as legitimate targets for intervention. Quality of life is being recognized as an increasingly important dimension that needs to be addressed in any comprehensive assessment of outcome.

A review of quality of life studies suggests a split of professional opinion as to whether an individual's quality of life is best captured by objective or subjective measures. "Objective" indicators might include such variables as an individual's income and housing situation. "Subjective" measures, called "psychological indicators" (Zautra and Goodhardt, 1979), focus on an individual's perceptions of his or her life.

There is a variety of available quality of life instruments which conceptualize quality of life in a number of different ways. Some focus on self-reported happiness and perceptions of well-being (see, for example, Bradburn, 1969; Bradburn, 1965). Others focus on life satisfaction (Neugarten, Havighurst, and Tobin, 1961; Campbell, Converse, and Rodgers, 1976; Andrews and Withey, 1976; Flanagan, 1978); mental well-being (Beiser, 1974); and positive mental health (Jahoda, 1958; Wright, 1971; Zautra and Goodhart, 1979). There are also a number of instruments that focus on the more objective indicators of life quality (see, for example, Caro, 1981).

Two QOL instruments have been used in a number of settings and will provide some indication of the types of approaches used. The first is the Oregon Quality of Life Questionnaire

(OQLQ) developed by Douglas Bigelow, et al.; the second is the Quality of Circumstances of Disabled Persons, developed by Francis Caro.

Composed of four sets of scales -- personal adjustment, interpersonal adjustment, adjustment to productivity, and civic adjustment -- the OQLQ is administered to clients by trained interviewers.

Caro's Quality of Circumstances instrument contains items that measure somewhat more objective elements of the client's environment, though this scale also is sensitive to the individual's feelings concerning the adequacy of his life circumstances. The instrument contains items relevant to nine domains: shelter, nutrition, sleeping patterns, personal care, clothing, activity and self expression, health maintenance, mobility, and choice.

These instruments are fairly representative of those being used in QOL studies generally. While they provide a detailed and rich assessment of clients' living circumstances, they also are expensive to administer and require a high level of expertise for the data analysis.

Approach. Under the best of circumstances the measurement of treatment outcomes is still a difficult task. Even if one manages to develop outcome measures that are reliable, valid and sensitive enough to detect change, the problem of causality remains. Given the multiple influences on an individual's life, it is often difficult to attribute to the program in question observed changes in behavior, functioning or any other outcome indicator.

Further complicating outcome measurement is the fact that program goals often are articulated poorly and, in many cases, treatment goals are client specific (i.e., staff start with a client's status or level of functioning and identify a set of treatment goals that are appropriate for that individual). Outcome evaluation, as a result, needs to be sensitive to the very personal or individual nature of "success" in such programs, and methods appropriate to this orientation must be identified.

The time frame in which such analyses must take place also complicates outcome evaluation in psychosocial rehabilitation programs. These programs typically serve populations that are characterized by mental disabilities that are severe and of long duration. As a result, client change can be expected to occur slowly, and frequently in a non-linear fashion. Outcome measures need to be sensitive to the chronic and episodic nature of these disabilities and to the relatively long time required before change is likely to occur.

All of these factors result, in part, from the unique philosophy of psychosocial rehabilitation centers. They make outcome evaluation a complex task. In order to provide useful feedback on program performance, evaluation plans need to be sensitive to each of these issues.

The remainder of this section presents a framework for conducting outcome evaluations which are feasible at the program level. Assumptions underlying the framework are identified, examples of instruments are presented and described, and implementation and analysis issues are discussed.

Assumptions and Methodological Considerations. Several assumptions underlie the recommendations which follow. The first is that outcome is a multi-dimensional concept; therefore, attempts to measure it also should be multi-dimensional. There is no single indicator that adequately captures the phenomenon. Our evaluation framework reflects this complexity and includes several outcome measures.

The second assumption, somewhat self-evident, is that the outcome measures selected should be compatible with program philosophy. The measures recommended here are oriented toward level of functioning, community integration, and quality of life-- all of which have a particular salience for psychosocial rehabilitation programs.

The third assumption concerns the feasibility of conducting high quality, reliable evaluations at the program level. The outcome literature cited in the previous section provides numerous examples of very detailed and comprehensive evaluation studies, which cost a lot of money, involve some fairly sophisticated statistics, and were conducted by experienced researchers. For small programs lacking specialized research staff and other resources for research, some of these endeavors may appear to be a bit daunting. However, we believe small programs can conduct targeted outcome evaluations which will provide useful feedback and can be used to monitor program operations and plan for program change.

Our fourth and final assumption is that, given the philosophy of psychosocial programs, outcome information should come from a number of different sources--not just the client's therapist. Sources should include the case manager/therapist/ staff, the client, and the client's family members or significant others.

Instruments. Instrument construction is a time consuming task, generally involving extensive reviews of the literature, form design, pretesting, and redesigning on the basis of pretest information. In some cases, designing new forms is an unavoidable part of the research process. But, for small programs trying to do credible evaluations amid the overwhelming demands of service delivery, it makes more sense to try to identify instruments, or sections of instruments, that already have been field tested and that are known to be reasonably valid and reliable. Exhibits 11 and 12 contain sections of instruments that measure outcomes and quality of life and that have been used with persons with chronic mental illness.

- Outcome Measures

The instrument attached as Exhibit 12 contains selected measures from the Uniform Client Data Instrument (UCDI). The UCDI was designed by CSP staff from/New York, Colorado, and Michigan, in collaboration with staff from NIMH. The instrument subsequently was modified by Human Services Research Institute. The UCDI captures four areas of client related information: demographics, clinical history, adjustment to the environment, and service utilization. The measures included here are those that relate to outcome: employment status, living arrangement,

EXHIBIT 12

OUTCOME MEASURES

1. Indicate client's current living arrangement (Circle one code only)

Inpatient of a psychiatric hospital or facility	01
Skilled nursing facility— 24 hours	02
Intermediate care facility- less than 24 hours	03
Supervised group living	04
Transitional group home	05
Family foster care	06
Cooperative apt., supervised	07
Cooperative apt, unsupervised	08
Board and care home	09
Boarding house (including meals, no supervision or program)	10
Rooming or boarding house or hotel	11
Private house or apt.	12
No regular residence	13
Other (Specify)	97
Don't know	98

2. Does client have family living nearby (within one hour of driving time)?

Yes and family is involved with client or staff	1
Yes, but family is not involved with client or staff	2
Yes, but don't know if family is involved with client or staff	3
No	4
Don't know	5

3a. Does client currently have any type of job?

Yes	1
No	2
Don't know	3

3b. Indicate type of job. (Circle one code only)

Competitive job (paid, obtained on the open market)	1
Transitional employment (paid job through CSP)	2
Work training (pre-vocational readiness, unpaid)	3
Sheltered workshop	4
Volunteer position, Specify:	5
Other type of job. Specify:	6
Don't know	8

4. If client is not currently employed, indicate why. (Circle one code only)

Temporarily laid off	1
Physically disabled/unable to work	2
Mentally disabled/unable to work	3
Retired	4
Student (full-time)	5
Homemaker (full-time)	6
Other (Specify)	7
Don't know	8

5a. Indicate all known sources of client's income (Circle all that apply)

Earned income	01
Social Security Benefits	02
Social Security Disability Income	03
Supplemental Security Income	04
Armed Service connected disability payments	05
Social Welfare Benefits-state or county (ADF, food stamps)	06
Vocational program (CETA, vocational rehabilitation, sheltered workshop)	07
Unemployment compensation	08
Retirement, investment or savings, pension	09
Rent supplements	10
Alimony and child support	11
Family/spouse contribution	12
Other sources SPECIFY	97
Don't know	98

5b. Provide your best estimate of the client's total monthly income (before taxes) from all sources.

____________ Gross Monthly Income

6. Indicate the client's performance level on each of these Community Living Skills and Socialization Skills during the past month. (Circle one code only for each skill.)

	NO PROBLEM	MILD PROBLEM	MODERATE PROBLEM	SERIOUS PROBLEM	DOES NOT APPLY	DON'T KNOW
Uses available transportation on familiar routes	1	2	3	4	6	8
performs household chores	1	2	3	4	6	8
Prepares/obtains own meals	1	2	3	4	6	8
Maintains adequate diet	1	2	3	4	6	8
Uses available transportaion on unfamiliar routes	1	2	3	4	6	8
Manages available funds	1	2	3	4	6	8
Secures necessary support services	1	2	3	4	6	8
Engaged in recreational activities at home	1	2	3	4	6	8
Socialized with friends	1	2	3	4	6	8
Socialized with members of family	1	2	3	4	6	8
Engaged in scheduled daytime activites	1	2	3	4	6	8

Question 6 continued . . .	NO PROBLEM	MILD PROBLEM	MODERATE PROBLEM	SERIOUS PROBLEM	DOES NOT APPLY	DON'T KNOW
Attended club lodge or other meetings	1	2	3	4	6	8
Attended church or other religious svcs	1	2	3	4	6	8
Engaged alone in recreational activities outside home	1	2	3	4	6	8
Engaged with others in recreational activites outside home	1	2	3	4	6	8

7. Answer the following questions about Criminal Activites using the frequency code. (Circle one code for each question)

	NOT AT ALL	ONE TIME	2 OR MORE TIMES	DON'T KNOW
Has the client been picked up or arrested for any type of crime in the last month?	1	2	3	8
Has the client been picked up or arrested for any type of crime in the last year?	1	2	3	8
Has the client been a victim of criminal activity in the past month?	1	2	3	8
Has the client been a victim of criminal activity in the past year?	1	2	3	8

8. Indicate client's performance level on each of these Personal Care Skills & Inappropriate Behaviors during the past month. (Circle one code for each item)

	NO PROBLEM	MILD PROBLEM	MODERATE PROBLEM	SERIOUS PROBLEM	DON'T KNOW
Incontinence	1	2	3	4	8
Walks/gets around	1	2	3	4	8
Dresses self	1	2	3	4	8
Maintains personal hygeine	1	2	3	4	8
Made suicidal threat or attempt	1	2	3	4	8
Had trouble at work or school	1	2	3	4	8
Had trouble in household	1	2	3	4	8
Destroyed/stole property	1	2	3	4	8
Had trouble with the law	1	2	3	4	8
Made violent threats or attempts	1	2	3	4	8
Caused community complaints	1	2	3	4	8
Exhibited temper tantrums	1	2	3	4	8
Engaged in bizarre behavior	1	2	3	4	8
Caused complaints from household	1	2	3	4	8
Abused drugs	1	2	3	4	8
Abused alcohol	1	2	3	4	8

level of income, source of income, family involvement, community living skills, socialization skills, personal care skills, and criminal activities and/or victimization.

These particular measures were selected because they reflect community functioning and integration, the two outcome areas that are most consistent with the philosophy of psychosocial rehabilitation. The UCDI has been field tested in two large survey studies (Market Facts, 1981; Mulkern, et al., 1986). Case managers, therapists, or other staff familiar with the client are the sources of information.

- Quality of Life Measures

Exhibit 13 provides an example of a quality of life instrument that is appropriate for use with clients with chronic mental illness. Measures on this instrument come from four sources: the Oregon Quality of Life Questionnaire (Bigelow, et al., 1980), the Quality of Circumstances of Disabled Persons Survey (Caro, undated), the Client's Quality of Life Interview (HSRI, 1984), and the Social Network Inventory (Anderson, 1979).

Measures included on this instrument are: leisure time activities, adequacy of finances, satisfaction with residence, satisfaction with neighborhood, and satisfaction with relationships.

Implementation /Analysis.

- Longitudinal Data

In order to measure changes in level of functioning (as opposed to level of functioning at a particular time) data have to be collected at multiple time points. Time 1 and time 2

EXHIBIT 13

QUALITY OF LIFE

We are interested in how you are doing in the Community Support Program. First, I would like to ask you about how you spend your time.

1. On a usual day, how much time do you spend (a/b/c): Is it all of your time, most of your time, or none of your time?

	ALL	MOST	SOME	NONE
a. with friends?	4	3	2	1
b. with relatives?	4	3	2	1
c. alone?	4	3	2	1

2. How often do you find yourself sitting around with nothing to do? Is it?

all of the time,	4
most of the time,	3
once in a while, or	2
never?	1

3. What would you like to do with your time? (PROBE)

Don't know	8

4. What stops you from doing (this/these things)? (PROBE)

5. Do you have a regular place to live?

yes	1
no	2

6. Do you have enough money each month to cover:

	YES	NO
food?	1	2
clothing?	1	2
rent?	1	2
medical care?	1	2
traveling for work, shopping, medical appts?	1	2
traveling to visist friends and relatives?	1	2
social activities like movies or restaurants?	1	2

7. I will read a list of things about your home. Please tell me if you are very satisfied, satisfied, dissatisfied or very dissatisfied with each of these things: (REPEAT RESPONSE ALTERNATIVES WHEN NECESSARY)

	VERY SATISFIED	SATISFIED	DISSATISFIED	VERY DISSATISFIED
its condition or state of repair	1	2	3	4
the amount of room or space it has	1	2	3	4
the amount of privacy you have	1	2	3	4
its security or safety	1	2	3	4
your neighbors	1	2	3	4
its convenience to stores & shopping	1	2	3	4

8. Would you say that the neighborhood where you live is:

very safe,	1
safe if you are careful	2
a little dangerous, or	3
not safe?	4

9. Overall, has your relationship with the people at (name of CSP) made your life:

much better	1
a little better	2
no different	3
a little worse, or	4
much worse?	5

END OF INTERVIEW

Thank you for helping me by answering these questions.

Source: Uniform Client Data Instrument (NIMH), Human Services Research Institute, 1978.

scores then can be compared to give an indication of the presumed effect of treatment.

However, even with longitudinal data, change scores from a single program are difficult to interpret by themselves. In the absence of comparison data, it is nearly impossible to establish whether a program is successful. For example, suppose that an evaluation study revealed that one-quarter of clients discharged to the community from psychiatric hospitals were readmitted to a hospital during a twelve month follow-up period. By itself, this figure is difficult to interpret. If other programs experience higher recidivism rates, then this 25% percent figure would sound good. On the other hand, if recidivism rates of 10% or 15% were the norm, then this program would be hard pressed to consider itself successful. The literature on outcome research in psychosocial rehabilitation programs and other similar community based programs contains examples of a number of different ways of handling this need for comparisons or norms. The experimental design is the classic and most rigorous method employing random assignment to treatment and control groups and pre- and post-test measures.

For a number of reasons, one of which is ethical considerations, the classical experiment is rarely feasible in ongoing programs. A more practical approach, and the one recommended here, is to use research subjects (clients) as their own controls. This involves a comparison of the client's status on outcome indicators before and after treatment (or at two different points in time during treatment).

- Data Collection

Data for the outcome questionnaire are supplied by the case manager, therapist, or other staff member familiar with the client. The information that is needed to fill out the form can be obtained from client records or on the basis of the respondent's knowledge of the client. In order to reduce bias, data for the quality of life questionnaire should come directly from the client. These data could be collected through interviews or by a mail survey.

In both cases, the first data collection point constitutes the baseline. These data can be used by themselves to describe the caseload in terms of functioning, employment, and quality of life. Second and succeeding administrations will collect data that can be compared with baseline figures to document progress over the study period. Data should be collected at least annually, but if resources permit, a six month interval could be used.

- Data Analysis

The first task of this type of analysis is to examine the distribution of change scores over time. Simple tables can be constructed to show the percent of clients who improved during the interval, the percent who remained stable, and the percent who deteriorated. This is an interesting exercise in and of itself; however, the data are somewhat difficult to interpret. For example, how much collective improvement does one need to observe before you are willing to call a program a success? One advantage of using instruments which have been fielded elsewhere is that there are norms available against which a program can measure its performance.

An equally interesting question is who changes? Most studies of treatment outcome use a fairly standard approach. The first step is to use correlation analysis to get a sense of which variables are related to the dependent variables and which independent variables are related to each other. After examining the zero order correlations, multiple regression can be used to suggest the relative importance of each variable and the proportion of the variance that is explained by the particular set of independent variables.

VI. OUTPUT/OUTCOME

Background.

Very little of the literature reviewed for this project included systematic cost effectiveness assessments. Those authors that addressed the issue usually used very simple calculations of per diem rates derived from a division of the number of clients into total agency budgets (Cohen, Sichel, and Berger, 1977; Mulder, 1982; Alaska, 1984; Stein, Test, and Marx, 1975). A few of the materials reviewed did describe more sophisticated analyses of effectiveness and cost indicators (Smith, 1975; Weisbrod, Test & Stein 1980; Cogswell et al., 1985), but these were the exceptions.

One project worth noting for future reference is that being undertaken under contract to the National Institute of Mental Health (Contact: Paul Widen, Division of Biometry and Applied Sciences, National Institute of Mental Health, 5600 Fishers Lane, Rockville, MD, 20857). A cost-outcome methodology for application with programs serving persons with chronic mental illness has been developed and is being field tested in two states. The Uniform Client Data Instrument (UCDI) is being used to collect the client outcome indices. The project is to be completed on December 31, 1987.

We also reviewed surveys of cost effectiveness studies. Rich, Bednarz, Westra, and Goldsmith (1984) describe several case examples that illustrate the application of cost benefit methods, providing step-by-step descriptions of the complete process with flow charts and diagrams. Rich and Goldsmith (1982) critique several approaches to cost benefit analysis that focus on cost measurements. They note the importance of discounting the time value of costs, identifying non-dollar costs, recognizing opportunity costs, and distinguishing between marginal and fixed costs. Frank (1981) discusses the problems of estimating non-quantifiable benefits of mental health services and briefly describes marginal benefit and cost effectiveness analyses. He also includes several case studies of cost benefit analyses.

Approach.

The comparative evaluation of costs per unit of service allows one to provide reasonable assessments of the cost of providing services. But the ultimate cost evaluation measures are those that provide some indication of both the impact of the services on clients and of their value to society relative to costs. When the outcomes are valued in monetary terms the evaluation of costs relative to outcomes is termed cost/benefit evaluation; when the outcomes are valued in non-monetary terms, the result is cost effectiveness evaluation. Strictly speaking, outcome measures alone represent "true" measures of program efficiency on effectiveness. It is only with these measures that one can tell whether the intermediate outputs have been at all useful -- that they have had some desired effect. In these analyses, costs and outcomes tend to be defined broadly: they are intended to measure not only client benefits and agency costs, but societal benefits and costs as well.

It is important to remember that cost/benefit and cost/effectiveness evaluations are intended to assist public policy makers in making choices among different programmatic approaches. They are not intended, nor are they appropriate, to inform choices among particular providers. Thus, these techniques are of import to psychosocial agencies only to the extent that the latter are themselves party to such evaluations and are in a position to influence them. Psychosocial rehabilitation agencies should not be subject to such evaluations individually.

Cost/Benefit Analyses

Cost benefit analysis allows one to compare the costs and benefits to society of the various program alternatives for persons with chronic mental illness. As explained by Rothenberg (1975), "in its most refined form, the technique can be used to take account of such complexities as characterized by differences in the time allocation of benefits and costs and differences in who receives the benefits and who pays the costs...? Moreover, since there is an attempt to compare the monetary value of benefits with the monetary value of costs, the cost benefit calculus enables the evaluator to use a common yardstick to assess the relative attractiveness of alternatives. Thus, by calculating the costs and benefits of policy alternatives in terms of monetary values, one can compare such dimensions as rates of return on investment, net differences between costs and benefits (net present values), and benefit-to-cost ratios. Of course no alternative would be undertaken whose costs exceed benefits, and in general the ones that would be selected would be those that maximized the total societal benefits relative to costs."

Cost/benefit evaluations are important if policy makers are to appreciate fully the larger costs and benefits to society that attend the psychosocial rehabilitation of persons with chronic mental illness; however, the difficulty comes in assigning monetary value to these costs and benefits. Resting on a series of broad assumptions, the bases or rationales for arriving at social cost and benefit estimates necessarily become highly theoretical. In this type of cost evaluation, the costs involved in providing psychosocial rehabilitation services are defined as representing more then the financial outlays required to produce the services. There are opportunity costs and societal costs as well.

Opportunity costs include the costs of goods or services that are foregone by virtue of their expenditure for the psychosocial rehabiliation program or component service(s). Theoretically, the time that a person with chronic mental illness who is capable of working (producing goods and services) spends in psychosocial rehabilitation service represents a cost to the individual (i.e., lost earnings), and a cost to society (i.e., foregone production of goods and services). Similarly, the market value of contributed goods and volunteer time spent in producing services would be counted as opportunity cost. Not only could they be employed for alternative purposes, but the earnings that might accrue from the non-expensed (undepreciated) portion of the investments in program facilities and equipment would represent an opportunity cost, in that these funds could be invested elsewhere.

Social costs could include a multiplicity of costs connected with the support of a person with chronic mental illness: the costs of law enforcement services for clients who are vagrant or who commit criminal acts, and the cash or in-kind contributions of the chronically mentally ill person's family.

Benefits to society likewise may be viewed principally in economic terms using such indicators as discounted future earnings over a person's lifetime may be used, or less productivity oriented measures, i.e., as the economic value persons would place on their own lives using life insurance as the surrogate, or the maximum prices that members of society would be willing to pay to have the program carried out. A very comprehensive and clear explanation of alternative schemes for valuing benefits and costs is provided by Thompson (1980).

Cost Effectiveness Analyses. The assumption that the benefits or outcomes can be valued by their market prices or those of similar alternatives is crucial for performing cost/benefit analyses of alternatives. Yet, many of the outcomes of psychosocial rehabilitation programs have no market counterpart. For instance, what is the market price to attach to the improved social functioning of a person with chronic mental illness? What is the market price to attach to the improved ability of a person with chronic mental illness to live independently in the community? Allowing one to express such outcomes in non-monetary terms, cost-effectiveness analysis also enables one to examine the relative costs of alternative programs for achieving particular types of outcomes. But it does not allow one to compare program costs directly with benefits. That is, the cost effectiveness approach enables one to rank potential program choices according to the magnitude of their effects relative to their costs, but not to ascertain whether a particular program is "worth it" in the sense that benefits exceed costs. This is because the latter generally are expressed in monetary units; the former, rendered in non-monetary units of effectiveness.

VII. CONCLUSION

This final section of the monograph includes a discussion of some general issues that administrators of psychosocial rehabilitation programs and others are likely to encounter as they implement an evaluation design. Topics briefly covered include the recommended phases of an evalution design, the types of individuals and organizations that can assist the administrator in carrying out an evaluation, the level of accuracy and precision that should be reflected in the evaluation methodology, and the use to which evaluation findings can be put.

Prior to developing a plan for program evaluation, it is important to pause and review the reasons why evaluation is important. Insofar as the field of pyschosocial rehabilitation, evaluation is an important means of documenting program content, service approaches, and program results. Such documentation is important to the replication and expansion of psychosocial rehabilitation techniques around the country. Evaluation results also serve an important function with respect to funding bodies at the local, state and federal level. Specifically, results are important to document what those in the field already believe -- that psychosocial rehabilitation programs are cost-effective alternatives to more restrictive, medically-oriented services.

As noted earlier, evaluation is important to the internal as well as the external functioning of the agency. Periodic evaluation activities provide the information necessary for managers to assess issues such as staff deployment, program practices, and program results. Evaluation provides a means for re-energizing the agency's program and providing staff with direct feedback about program efficacy and coherence.

Implementing an Evaluation Plan

The ultimate aim of evaluators within a psychosocial rehabilitation program should be to develop a comprehensive plan for assessing program viability and efficacy. Obviously, given resource limitations and the stage of development of an agency, such plans can not be implemented all at one time. Therefore, when choices must be made about which aspects of an evaluation plan to begin first, the initial focus should be on the capacity of the agency to provide psychosocial rehabilitation services. Capacity has been defined in this monograph to include the agency's mission, staff competency, and financial condition. Other areas that can be included in this phase include an exploration of the appropriateness of the physical plant in which the program is located (e.g., is it human scale? comfortable? homelike, etc.), the location of the program (e.g., is it close to public transportation, is it in a safe area? etc.), and the representativeness of the board of directors (e.g, is it reflective of the community? does it include consumers as well as professionals? etc.)

Once a mechanism is in place to assess capacity, the next phase is to craft a system for monitoring the conduct of the program and the extent to which the service process embodies the principles of psychosocial rehabilitation. The monograph covers three important areas of the process of service delivery -- program practices, program connectedness, and "match-to-need," or the extent to which the services actually provided conform to what the client needs. Other areas of service conduct that can be taken into account during this phase include the quality of the staff and client interaction (e.g., are clients treated with dignity? are their views and opinions solicited? etc.), the oversight of medication administration (e.g., are regular checks made to determine possible side-effects? are clients informed about potential risks? is there a full medical history in the client's record? etc.).

Following the creation of an evaluation scheme to assess service process, the next step is to set in motion a means for measuring program outputs. Those suggested in the monograph include the agency's financial as well as staff productivity. Additional outputs might include numbers of staff receiving periodic skills training, number of board meetings held, numbers of clients dropping out of the program, and number of grievances filed.

The next step in an evaluation plan is to assess the extent to which the services offered were successful from the point-of-view of the client as well as the client's family or other significant friends. Further, the monograph recommends that program results also be assessed in terms of such client variables as securing employment, maintaining stable housing, and minimizing contact with the mental health system. Other outcomes not noted have to do with measured increases in staff competency, staff satisfaction, and increased community acceptance of persons with serious mental health problems.

Finally, administrators can, during the final phases of an evaluation, link program outputs (costs per unit of service) with client outcome information to generate a cost benefit or cost effectiveness ratio.

Who Does Evaluation?

In large agencies, there may be a full-time staff member responsible for evaluation. However, in small psychosocial rehabilitation agencies, such as social clubs, implementing an evaluation plan will fall on individuals with other staff responsibilities. It is useful, therefore, to think of evaluation as an agency and community wide endeavor that involves a variety of actors both as respondents and assesors. Specifically, the evaluation design should contemplate participation by clients, families and friends, members of the board of directors, staff, and lay persons in the community. Additional information and references concerning the use of such groups can be found in Assessing and Enhancing the Quality of Human Services: A Guide for the Field (Bradley, et al., 1985), and Citizen Evaluation in Practice: A Casebook on Citizen Evaluation of Mental Health and Other Services (Bradley, Allard and Mulkern,1984).

With respect to clients and families, they can function as respondents to surveys on satisfaction and client outcome, and can also be pressed into service to assist with evaluation design and to conduct key informant interviews. Members of the board of directors are a valuable resource to the agency and can serve as observers of the service delivery process (e.g., to determine how clients are dealt with by staff, how client views are solicited, how the intake process is carried out, etc.), and can also survey community reactions to the program through key informant interviews. By giving board members a specific responsibility, it will enhance their connection to the agency and should expand their commitment.

Individuals from the community can also be recruited to conduct an external evaluation of the program including interviewing staff to determine their perceptions of agency strengths and weaknesses as well as the clients and their families. Using persons outside the agency as a periodic evaluation resource enhances the agencies connections with the community and helps to build a basis of support for the program. Finally, staff at all levels can serve as respondents to surveys regarding process as well as outcomes, and can also function as interviewers of community key informants.

Even in those agencies that do have staff assigned to evaluation positions, including a range of interested groups in the conduct of evaluation is important both because it is in keeping with the mission of psychosocial rehabilitation programs and it enhances the role and connection of each of these constituencies.

There are also technical resources that may be made available to the program for little or no cost. The first place to turn is to the local community or four year college. Faculty in computer sciences may be willing to assist in setting up a simple set of file for evaluation results on a microcompter. Students may be interested in providing assistance as part of independent study placements or for purposes of graduate theses. Members of the board of directors may have specialized skills such as accounting or public relations that may be useful in the evaluation design phases.

Further, local and state Community Support Program staff may have written materials, reports, and guides in their libraries. They may also be willing to spend time with agency staff and assist in developing the evalulation plan. Finally, the agency may be in a position to seek pro bono assistance from major for profit management consulting firms. Many of the so-call "big eight" consulting firms have pro bono policies that allow their employees to contribute a certain amount of time to charitable purposes. This is also the case with some of the major computer companies such as IBM.

Finally, it may be necessary to hire a consultant to assist in the development of the plan. In order to identify an appropriate individual, the administrator may want to contact the International Association of Psychosocial Rehabilitation Services or the Non-Profit Management Association.

Evaluation Research vs. Program Evaluation

Throughout this document we have tried to make the distinction between program evaluation and evaluation research. For many of the more descriptive areas addressed in the monograph, the distinction is not crucial. This includes areas that do not involve hypothesis testing (description of ageny mission, developing profiles of client characteristics and service needs, etc.). The issue is more pronouced when the evaluator attempts to test hypotheses concerning program effectiveness and, as a result, needs to control the research setting to a greater extent.

There has been continuing debate concerning the possibility of conducting outcome evaluation research at the program or agency level (see for example Ciarlo, 1982; Hargreaves, 1982; and Newman, 1982). The debate has centered on whether reliable and valid outcome data can be obtained outside of the classic experimental model.

Certainly there is an appropriate place for treatment research as defined by Hargreaves. This is targeted research aimed at identifying the impact of an intervention that is delivered in relatively controlled settings. This means that the researcher has control over who receives the intervention and at least some of the potentially confounding influences that could distort the research findings. The most frequently used and most respected methodological design for treatment research is the classic experimental model with random assignment to test and control group settings.

This is a slow process. It is also a costly one that requires considerable effort and expertise. However costly, treatment research plays a vital role in our understanding of treatment effectiveness. It is clear that we need more information on what types of interventions worksbest for what types of clients under what circumstances.

Conducting this type of carefully controlled, long range research is virtually impossible at the program or agency level. Few agencies have the resources to support the staff required to conduct such studies and even fewer can set up the sort of sterile conditions that are necessary to avoid contaminating the research results. The fact remains, however, that program managers need to know something about the fate of their clients in order to manage their programs responsibly. They need to know whether their clients are spending too much time hospitalized, how many clients are finding employment, and whether clients are making any gains in terms of community functioning. The information has to be collected routinely and it has to be fed back to the people who make decisions about programs. This includes program directors and administrators, unit or service directors, program staff, and legislators who control the program's funding.

Obstacles to conducting sound outcome research remain. The available instruments are not perfect and our ability to isolate treatment interventions is far from complete. We agree with Ciarlo, however, when he writes (1982, p. 36):

> ....we need not wait until all such obstacles are removed and the measures in hand are perfect: they will never be perfect. A better strategy would be to choose carefully among available measurement techniques, recognize their specific limitations, compensate as well as possible with study designs or measure modifications, and begin the process of implementing outcome evaluation accountability in many of our programs.

We have tried to select some instruments that will provide information to program managers and program planners and, at the same time, will not impose an unreasonable reporting burden on direct service staff.

Uses of Evaluation

Program evaluation is a fairly futile activity unless the results of the research are disseminated widely and have an impact on programs. There are numerous techniques that evaluators can use to ensure the visibility of evaluation and monitoring results and the ultimate implementation of recommendations. The failure to give adequate consideration to a strategy for disseminating study results and for maximizing the chances that recommendations will be implemented is a serious shortcoming of many evaluation studies. In conducting service assessments, evaluators often focus too much energy on the study process itself. No matter how well the evaluation process is carried out, it is unlikely that the study will have its intended effects without a proportional expenditure of effort on dissemination.

Perhaps the most direct way to disseminate evaluation results is through agency debriefing. This means simply that the evaluators or monitors communicate their findings and recommendations directly to the program administrators and staff. This ensures that the results will recive a fair hearing.

A second strategy is to include research recommendations in the agency's annual plan. This is a useful dissemination strategy since it establishes a benchmark against which the next year's performance can be measured.

Another strategy that may be useful on occasion is enlisting the support of state or local legislators. This is a useful technique that brings necessary information to the groups that control the allocation of resources. Legislatures are beginning to demand more accountability from programs that use public funds. Any information that can document the amount and types of services that have been bought with these dollars will certainly be welcome. Any information that documents service effectiveness will be even more welcome!

Finally, evaluators and program administrators alike can make use of professional journals and association meetings to disseminate their findings to a wider range of persons with similar needs and concerns. In this way information on both successful programs and successful program evaluation strategies can be brought to the attention of the most relevant audience.

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APPENDIX

MEMBERSHIP SURVEY

PART I: THIS SECTION IS TO BE ANSWERED BY ALL MEMBERS.

1) How long have you been a member of Fellowship House?

		1985		1984	
		N	Percent	N	Percent
Less than one year		25	29.8%	38	37.6%
Longer than one year		59	70.2	63	62.4
	TOTAL	84	100.0%	101	100.0%

2) Sex

		1985		1984	
		N	Percent	N	Percent
Male		59	67.8%	65	63.7%
Female		28	32.2	37	36.3
	TOTAL	87	100.0%	84	100.0%

3) Ethnicity

		1985		1984	
		N	Percent	N	Percent
Anglo		53	65.4%	61	67.0%
Black		11	13.6	7	7.7
Hispanic		11	13.6	12	13.2
Other		6	7.4	11	12.1
	TOTAL	81	100.0%	90	100.0%

4) Age

		1985		1984	
		N	Percent	N	Percent
-25		12	14.5%	N/A	
25-34		40	48.2		
35-44		16	19.2		
45+		15	18.1		
	TOTAL	83	100.0%		

5) The time it took me to become a member of Fellowship House was:

		1985		1984*	
		N	Percent	N	Percent
Too long		15	18.1%	14	15.4%
Reasonable		68	81.9	77	84.6
	TOTAL	83	100.0%	91	100/0%

* 1984 had "The time between my intake interview and acceptance into FH was:"

6) Do you feel that Fellowship House is open at times which are convenient

		1985		1984	
		N	Percent	N	Percent
Yes		70	81.4%	84	84.8%
No		13	15.1	10	10.1
I am not sure what time Fellowship House is open.		3	3.5	5	5.1
	TOTAL	86	100.0%	99	100.0%

7) Have you been prevented from receiving services because of:

	1985		1984	
	N	Percent	N	Percent
Travel difficulties	19	21.6%	22	21.0%
Cost of Social Activities	6	6.8%	8	7.6%
Vocational Fees	8	9.1%	5	4.8%
Residential Fees	9	10.2%	10	9.5%

8) How long do you have to travel to reach Fellowship House?

		1985		1984	
		N	Percent	N	Percent
30 minutes or less		70	81.4%	67	69.1%
31 - 60 minutes		10	11.6	14	14.4
1 hour or more		6	7.0	16	16.5
	TOTAL	86	100.0%	97	100.0%

9) Duplicate discarded:

10) If you use FH vans, is service:

		1985		1984	
		N	Percent	N	Percent
Good		30	42.3%	50	69.4%
Adequate		29	40.8	16	22.2
Bad		12	16.9	6	8.3
	TOTAL	71	100.0%	72	100.0%

11) Do you feel physically safe while you are at the Fellowship House Clubhouse

		1985		1984	
		N	Percent	N	Percent
Always		63	75.0%	yes 85	91.4%
Sometimes		17	20.2		
Never		4	4.8	no 8	8.6
	TOTAL	84	100.0%	93	100.0%

12) Are you treated with courtesy and respect by FH receptionists and clerks?

	1985		1984	
	N	Percent	N	Percent
Yes, very much	57	67.1%	68	70.1%
Yes, somewhat	23	27.1	24	24.7
Not very much	3	3.5	3	3.1
Not at all	2	2.4	2	2.1
TOTAL	85	100.0%	97	100.0%

13) Do you feel comfortable talking with staff other than advisors or aides?

	1985		1984	
	N	Percent	N	Percent
Yes, very much	43	51.2%	61	62.2%
Yes, somewhat	28	33.3	26	26.6
No, not very much	9	10.7	7	7.1
No, not at all	4	4.8	4	4.1
TOTAL	84	100.0%	98	100.0%

* Do you feel comfortable talking with Administrative Staff?

14) Have you had problems talking to staff because:

	1985		1984	
	N	Percent	N	Percent
They do not speak your language?	5	5.7%	9	8.6%
Other communication problems?	20	22.7%	14	13.3%

15) Have you had any problems at Fellowship House because of your:

	1985		1984	
	N	Percent	N	Percent
Race	6	6.8%	4	3.8%
Culture	5	5.7%	8	7.7
Age	7	8.0%	10	9.5
Sex	6	6.8%	7	6.7
Education	11	12.5%		
Income	12	13.6%		

16) How helpful has Fellowship House staff been at aiding you in getting other community services (Food Stamps, Welfare, etc.)?

	1985		1984	
	N	Percent	N	Percent
Very helpful	46	59.0%	47	52.8%
Slightly helpful	8	10.3	16	18.0
Not helpful	5	6.4	8	9.0
I did not need help	19	24.4	18	20.2
TOTAL	78	100.0%	89	100.0%

17) If a friend was in need of similar help, would you recommend him or her for:

Social Program	1985		1984	
	N	Percent	N	Percent
Yes	59	89.4	80	95.2%
No	7	10.6	4	4.8
TOTAL	66	100.0%	84	100.0%

Vocational Program	1985		1984	
	N	Percent	N	Percent
Yes	55	84.6%	66	91.7%
No	10	15.4	6	8.3
	65	100.0%	72	100.0%

Residential Program	1985		1984	
	N	Percent	N	Percent
Yes	47	82.5%	55	84.6%
No	10	17.5	10	15.4
TOTAL	57	100.0%	65	100.0%

18) Overall, have the services you received helped you to deal more effectively with your problems?

	1985		1984	
	N	Percent	N	Percent
Yes, a great deal	46	55.4%	59	61.5%
Slightly helpful	27	32.5	33	34.4
Not helpful	7	8.5	1	1.0
I did not need help	3	3.6	3	3.1
TOTAL	83	100.0%	96	100.0%

19) During your membership at Fellowship House have services:

	1985		1984	
	N	Percent	N	Percent
Improved?	43	52.4%	42	43.3%
Stayed the same	30	36.6	47	48.5
Gotten worse	9	11.0	8	8.2
TOTAL	82	100.0%	97	100.0%

20) What changes have you noticed (good and bad) at Fellowship House since you entered program?

Comments only

PART II. SOCIAL PROGRAM - THIS SECTION TO BE ANSWERED BY ALL MEMBERS.

21) How would you rate the variety in Social Program activities?

	1985		1984	
	N	Percent	N	Percent
Quite a lot	36	45.6%	32	35.6%
Just right	29	36.7	39	43.3
Not enough	14	17.7	19	21.1
TOTAL	79	100.0%	90	100.0%

22) Do you feel you have enough opportunity to help plan activities for Social Program?

	1985		1984	
	N	Percent	N	Percent
Yes, very much	35	45.6%	37	40.7%
Yes, somewhat	27	35.1	39	42.9
No, not enough	6	7.8	3	9.9
No, not all all	9	11.7	6	6.6
	77	100.0%	85	100.0%

23) Do you feel that FH provides enough activities during holiday seasons Christmas, Thanksgiving, Valentines Day, etc.)?

	1985		1984	
	N	Percent	N	Percent
Yes, very much	54	69.2%	N/A	
Yes, somewhat	16	20.5		
No, not enough	2	2.6		
No, not all all	6	7.7		
TOTAL	78	100.0%		

24) Are you treated with courtesy and respect by Social Program Staff?

	1985		1984	
	N	Percent	N	Percent
Yes, very much	52	66.7%	63	66.3%
Yes, most of the time	21	26.9	29	30.5
No, not very much	4	5.1	2	2.1
No, not all all	1	1.3	1	1.1
TOTAL	78	100.0%	95	100.0%

25) Do you feel that Social Program staff are concerned when you have a personal problem?

During Social Program hours:

	1985		1984	
	N	Percent	N	Percent
Very much	44	57.9%	52	55.9%
Somewhat	26	34.2	37	39.8
Not at all	6	7.9	4	4.3
TOTAL	76	100.0%	93	100.0%

At Other Times:

	1985		1984	
	N	Percent	N	Percent
Very much	22	50.0%	32	50.8%
Somewhat	15	34.1	26	41.3
Not at all	7	15.9	5	7.9
TOTAL	44	100.0%	63	100.0%

26) Do you feel that Social Program has helped you socially?

	1985		1984	
	N	Percent	N	Percent
Yes, very much	32	45.1	46	50.5%
Yes, somewhat	28	39.4	32	35.2
No, not enough	5	7.0	5	5.5
No, not at all	6	8.5	8	8.8
TOTAL	71	100.0%	91	100.0%

27) What do you like best in Social Program?

Comments only

28) What do you like least in Social Program?

Comments only

29) Other Social Program Comments:

Comments only

PART III. RESIDENTIAL PROGRAM

30) Which facility(s) have you been in?

	1985		1984	
	N	Percent	N	Percent
Manor	23	26.1%	30	28.6%
Supervised	38	43.2%	37	35.2%
Satellite	20	22.7%	16	15.2%

31) How much does living in Fellowship House Residence help you become more independent?

	1985		1984	
	N	Percent	N	Percent
Very much	28	58.3%	30	63.8%
Somewhat	11	22.9	14	29.8
Very little	4	8.3	2	4.3
Not at all	5	10.4	1	2.1
TOTAL	48	100.0%	47	100.0%

32) Are you treated with courtesy and respect by Residential Program staff?

	1985		1984	
	N	Percent	N	Percent
Yes, very much	26	49.1%	25	51.0%
Yes, somewhat	19	35.8	20	40.9
No, not very much	3	5.7	3	6.1
No, not at all	5	9.4	1	2.0
TOTAL	53	100.0%	49	100.0%

33) Is the number of Residential staff adequate?

	1985		1984	
	N	Percent	N	Percent
More than enough	21	42.9%	12	24.0%
Adequate	18	36.7	27	54.0
Hardly adequate	6	12.2	7	14.0
Not enough	4	8.2	4	8.0
TOTAL	49	100.0%	50	100.0%

34) How do you rate the number of social activities in Residence?

	1985		1984	
	N	Percent	N	Percent
More than enough	13	26.0%	9	19.6%
Adequate	21	42.0	23	50.1
Hardly adequate	4	8.0	5	10.9
Not enough	12	24.0	9	19.6
TOTAL	50	100.0%	43	100.0%

35) Do you feel physically safe in Residence?

	1985		1984	
	N	Percent	N	Percent
Always	33	67.3%	29	60.4%
Sometimes	15	30.6	18	37.5
Never	1	2.0	1	2.1
TOTAL	49	100.0%	48	100.0%

36) Are the furnishings in your apartment satisfactory?

	1985		1984	
	N	Percent	N	Percen
Very Satisfactory	20	39.2%	N/A	
Satisfactory	19	37.3		
Unsatisfactory	11	21.6		
Very Unsatisfactory	1	2.0		
TOTAL	51	100.0%		

37) Are the rules for living in a Fellowship House residence reasonable?

	1985		1984	
	N	Percent	N	Percent
Very reasonable	19	39.6%	15	31.3%
Reasonable	26	54.2	28	58.3
Unreasonable	2	4.2	4	8.3
Very unreasonable	1	2.1	1	2.1
TOTAL	48	100.0%	48	100.0%

38) Do you feel "at home" in your FH residence?

	1985		1984 *	
	N	Percent	N	Percent
Yes	32	65.3%	28	59.6%
Somewhat	10	20.4	11	23.4
No	7	14.3	8	17.0
TOTAL	49	100.0%	47	100.0%

* Do you feel your apartment is home?

39) Are there any other residential options besides the Manor, Supervised and Satellite that are needed.

	1985		1984	
	N	Percent	N	Percent
No	36	76.6%	28	65.1%
Yes	11	23.4	15	34.9
TOTAL			47	100.0%

40) What do you like best about Residence?

Comments only

41) What do you like least about Residence?

Comments only

42) Other Residential Comments:

Comments only

PART IV. VOCATIONAL PROGRAM

43) Do you feel that you get the individual time you need from your advisor?

	1985		1984	
	N	Percent	N	Percent
Always	35	61.4%	42	60.0%
Sometimes	21	36.8	23	32.9
Never	1	1.8	5	7.1
TOTAL	57	100.0%	70	100.0%

44) How would you rate the service you have received in vocational program?

	1985		1984	
	N	Percent	N	Percent
Excellent	29	50.0%	37	53.6%
Good	19	32.8	22	31.9
Fair	7	12.1	7	10.2
Poor	3	5.2	3	4.3
TOTAL	58	100.0%	69	100.0%

45) Are you treated with courtesy and respect by Vocational Program staff?

	1985		1984	
	N	Percent	N	Percent
Yes, very much	39	68.4%	52	75.4%
Yes, somewhat	15	26.3	15	21.8
No, not very much	2	3.5	1	1.4
No, not at all	1	1.8	1	1.4
TOTAL	57	100.0%	69	100.0%

46) What do you like best about Vocational Program?

Comments only

47) What do you like least about Vocational Program?

Comments only

IF YOU ATTEND WORK AREA ACTIVITIES THEN ANSWER QUESTIONS 48-52.

48) Is your work area activity is helping you to be productive?

	1985		1984	
	N	Percent	N	Percent
Yes, very much	27	48.2%	37	55.2%
Yes, somewhat	20	35.7	19	28.4
No, not very much	5	5.7	6	9.0
No, not at all	4	7.1	5	7.4
TOTAL	56	100.0%	67	100.0%

49) Are you in the work area that you would like to be in?

	1985		1984	
	N	Percent	N	Percent
Yes	43	79.6%	N/A	
No	11	20.4		
TOTAL	54	100.0%		

50) Do you feel that your work area activity is helping you to prepare for a job?

	1985		1984	
	N	Percent	N	Percent
Yes, very much	23	41.8%	32	44.4%
Yes, somewhat	19	34.5	21	29.2
No, not very much	9	16.4	12	16.7
No, not at all	4	7.3	7	9.7
TOTAL	56	100.0%	67	100.0%

51) Do you feel that your work area activity is interesting and challenging?

	1985		1984	
	N	Percent	N	Percent
Yes, very much	28	51.9%	36	52.2%
Yes, somewhat	13	24.1	23	33.3
No, not very much	7	13.0	5	7.2
No, not at all	6	11.1	5	7.2
TOTAL	54	100.0%	69	100.0%

52) Do you feel that Transitional Employment helps members to prepare for competitive employment?

	1985		1984	
	N	Percent	N	Percent
Yes, very much	31	58.5%	43	67.2%
Yes, somewhat	15	28.3	15	23.4
No, not very much	2	3.8	3	4.7
No, not at all	5	9.4	3	4.7
TOTAL	53	100.0%	64	100.0%

IF YOU ATTEND TRANSITIONAL EMPLOYMENT (T.E.), PLEASE ANSWER QUESTIONS 53-50.

53) Do you feel that there is enough variety in T.E. positions?

	1985		1984	
	N	Percent	N	Percent
Yes, very much	13	37.1%	9	29.0%
Yes, somewhat	12	34.3	11	35.5
No, not very much	6	17.1	8	25.8
No, not at all	4	11.4	3	9.7
TOTAL	35	100.0%	31	100.0%

54) What other T.E. jobs would you like to see?

Comments only

55) Does T.E. help you feel better about yourself?

	1985		1984	
	N	Percent	N	Percent
Yes, very much	13	37.1%	17	56.7%
Yes, somewhat	12	34.3	9	30.0
No, not very much	6	17.1	2	6.6
No, not at all	4	11.4	2	6.7
TOTAL	35	100.0%	30	100.0%